

IDRX 4 -
Olson-Kennedy *Misanin*
Deposition Transcript
(Public document)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

STERLING MISANIN, et al.,)	
)	
Plaintiffs,)	
)	
vs.)	Case No.
)	2:24-cv-04734-BHH
ALAN WILSON, in his official)	
capacity as the Attorney)	
General of South Carolina,)	
et al.,)	
)	
Defendants.)	
)	

VIDEOTAPED DEPOSITION OF JOHANNA OLSON-KENNEDY, M.D.,
taken on behalf of Plaintiffs, at ACLU of Southern
California, 1313 West Eighth Street, Suite 200,
Los Angeles, California 90017, beginning at
9:43 a.m., and ending at 1:31 p.m., on Monday,
October 7, 2024, before Marceline F. Noble, RPR, CRR,
Certified Shorthand Reporter No. 3024.

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(Via Zoom videoconference:)
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ABBY TABACHINI
GARREN MORTON
JUSTIN TERRANOVA

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INSTRUCTION NOT TO ANSWER
(None)

LOS ANGELES, CALIFORNIA
MONDAY, OCTOBER 7, 2024
9:43 a.m. - 1:31 p.m.

THE VIDEOGRAPHER: Ready to go?

MR. RAMER: Yes.

THE VIDEOGRAPHER: We are now on the record.

This begins videotape No. 1 in the deposition of Dr. Johanna Olson-Kennedy, in the matter of Sterling Misanin versus Alan Wilson, in the United States District Court, for the District of South Carolina, Charleston Division.

Case No. 2:24-cv-4734[sic]-BHH.

Today is October 7th, 2024, and the time is 9:43 a.m.

This deposition is being taken at ACLU of Southern California in Los Angeles, California 90017.

My name is Brian Kielhack of Magna Legal Services, and I will be your videographer for today.

Our court reporter is Marceline Noble.

Counsel, at this time I ask that you introduce yourselves, starting with our noticing attorney.

MR. RAMER: I am John Ramer of Cooper & Kirk, on behalf of defendants.

MR. SELDIN: Harper Seldin of the ACLU, on behalf of plaintiffs.

MS. CAROLAN: Aine Carolan of Selendy Gay, also on behalf of plaintiffs.

THE VIDEOGRAPHER: May counsel via Zoom -- go ahead.

THE WITNESS: I'm --

Sorry.

THE VIDEOGRAPHER: No. Go ahead.

MR. SMITH: I'm Emory Smith online, counsel for the defendants, with the South Carolina Attorney General's office.

And my understanding is, without objection, I have three interns with me, Abby Tabachini, Garren Morton, and Justin Terranova. They will be observing part of the deposition.

MR. McGRAY: My name is Ben McGray with the South Carolina's Attorney General's office. I'm not counsel of record.

I'm awaiting bar results, but I'm listening in by Zoom.

MS. SWAMINATHAN: Hi, there. My name is Sruti Swaminathan, counsel for plaintiffs, from the ACLU.

THE REPORTER: Who is Julie Singer?

MR. SELDIN: Julie Singer is for -- counsel with plaintiffs, with Selendy Gay.

JOHANNA OLSON-KENNEDY, M.D., having been first duly sworn, was examined and testified as follows:

THE REPORTER: Thank you.

EXAMINATION

BY MR. RAMER:

Q. Good morning, Dr. Olson-Kennedy.

A. Good morning.

Q. I know you've been deposed before, so this will be the same drill as usual. We'll try not to talk over one another.

I'll ask questions. If you don't understand my questions, just let me know.

And I know you're familiar with this, but according to the local rules, I'm supposed to instruct you that you should ask me rather than your own counsel for clarifications, definitions or explanations of any words, questions or documents presented during the course of the deposition.

Do you understand that?

A. I do.

Q. I'm going to aim to take breaks around the hour, but if you ever need a break at any point, just let me know. My only request is that you'd answer any pending questions.

Does that make sense?

A. Yes.

MR. RAMER: And we'll just start with some housekeeping. I'm going to hand the court reporter a document to be marked Olson-Kennedy Exhibit 1.

(Deposition Exhibit 1 was marked for identification by the court reporter.)

MR. SELDIN: And, Mr. Ramer, before we get into it, I just wanted to note for the record that I believe we have left unresolved whether this deposition time cuts into a total of seven hours for Dr. Olson-Kennedy or separate and apart. That's fine. The parties will sort it out later.

I just wanted to note that for the record.

MR. RAMER: And, yes. Defendants agree with your understanding.

Q. And, Dr. Olson-Kennedy, you've been handed what's been marked as Olson-Kennedy 1; correct?

A. Yes.

Q. And is this the declaration that you

submitted in this case?

A. Yes.

Q. And do you have any corrections or updates to it?

A. There are a handful of additional seminars and lectures that I've given, as well as two additional manuscripts that should be added to this.

I can provide that later.

Q. What are the topics of the manuscripts?

A. So the first one is a protocol for another study that I am a co-investigator on, that is about younger pre-pubertal trans and gender diverse youth, children.

And then the second one is another manuscript that comes from -- oh, no. That one's on here.

Hold on a second. Let me try and remember it.

I don't remember what the other one is, but I can get that one as well.

Q. And the first one you mentioned regarding the protocol for gender incongruence in children, can you explain a little bit more what that's about.

A. So this is another multisite study that I'm a part of. And that study is a prospective

longitudinal study looking at children who are prepubertal and their mental health over time and also their trajectories over time.

Q. When you say "trajectory," what do you mean by that?

A. Just how they grow up, what happens to them as they move into adolescence.

Q. And specifically do you mean their -- the gender identity trajectory?

A. Yes. Their gender expression, their gender identity, their mental health.

Q. And when you're measuring their mental health outcomes over time, are you measuring that in light of any particular intervention?

A. No.

Q. Do you consider social transition an intervention?

MR. SELDIN: Object to form.

THE WITNESS: I don't know the answer to that in this case. I think that in general, social transition is an intervention.

BY MR. RAMER:

Q. And when you say you don't know the answer to that in this case, what do you mean by that?

A. I am not certain if everybody who started

was socially transitioned at the beginning. And so as an intervention that happens over the course of time, I don't -- I just don't know.

Q. And so, in other words, in the study that we're discussing, that is not a variable that's counted for; is that right?

MR. SELDIN: Objection. Misstates testimony.

THE WITNESS: It's an observational study, so it's not an intervention study.

BY MR. RAMER:

Q. As part of this study, are you recording whether the subjects were socially transitioned?

A. Yes.

MR. SELDIN: Object to form.

THE WITNESS: Yes.

BY MR. RAMER:

Q. And has that protocol been published?

A. That's the protocol paper that I'm talking about.

Q. And so it has not been published.

A. It has been published. It's missing off my C.V.

Q. Understood. Thank you.

And sticking with Exhibit 1, going to

page 4, paragraph 18.

The first case listed here is Noe v Parson in Missouri state court; correct?

A. Yes.

MR. RAMER: I'm handing the court reporter a document I'll ask to be marked as Olson-Kennedy Exhibit 2.

(Deposition Exhibit 2 was marked for identification by the court reporter.)

THE WITNESS: Thank you.

BY MR. RAMER:

Q. And, Dr. Olson-Kennedy, is this the transcript of your deposition in Noe v Parson?

A. I would have to look through the whole thing to make sure.

Would you like me to do that?

Q. Does it appear to be the deposition of your -- excuse me -- the transcript of your deposition in Noe v Parson?

A. Yes.

MR. RAMER: Now I'm handing the court reporter a document I'll ask be marked as Olson-Kennedy 3.

(Deposition Exhibit 3 was marked for identification by the court reporter.)

1 BY MR. RAMER:

2 Q. And, Dr. Olson-Kennedy, you've been handed
3 what's been marked as Olson-Kennedy Exhibit 3.

4 Is this a copy of your errata sheet for your
5 transcript of Noe v Parson?

6 A. Yes.

7 Q. And did you give truthful testimony during
8 this deposition?

9 A. I did.

10 Q. And you've also recently testified in a
11 deposition in Voe versus Mansfield, a case regarding
12 North Carolina's ban on medicalized transition for
13 minors; correct?

14 A. Correct.

15 MR. RAMER: I'm handing the court reporter
16 what I'll ask be marked as Olson-Kennedy Exhibit 4.

17 (Deposition Exhibit 4 was marked for
18 identification by the court reporter.)

19 THE WITNESS: Thank you.

20 MR. SELDIN: Thank you.

21 BY MR. RAMER:

22 Q. And, Dr. Olson-Kennedy, does this appear to
23 be a copy of your deposition in Voe versus Mansfield?

24 A. Yes.

25 MR. RAMER: I'm handing the court reporter a

1 document that I'll ask be marked as Olson-Kennedy
2 Exhibit 5.

3 (Deposition Exhibit 5 was marked for
4 identification by the court reporter.)

5 THE WITNESS: Thank you.

6 BY MR. RAMER:

7 Q. And, Dr. Olson-Kennedy, is this document
8 that's been marked as Olson-Kennedy Exhibit 5, your
9 errata sheet for your deposition in Voe versus
10 Mansfield?

11 A. Yes.

12 MR. RAMER: I'm handing the court reporter a
13 document and I'll ask be marked Olson-Kennedy
14 Exhibit 6.

15 (Deposition Exhibit 6 was marked for
16 identification by the court reporter.)

17 THE WITNESS: Thank you.

18 BY MR. RAMER:

19 Q. I'm sorry. Before I turn to this document,
20 did you give truthful testimony during your
21 deposition in Voe versus Mansfield?

22 A. I did.

23 Q. And are you offering opinions in this case
24 that are consistent with the opinions you offered in
25 Voe versus Mansfield?

1 A. I am.

2 Q. Now, turning to the document that's been
3 marked as Olson-Kennedy 6, is this the amicus brief
4 that was submitted on your behalf in United States
5 versus Skrmetti, Case No. 23-477, in the Supreme
6 Court of the United States?

7 A. I don't know. I would have to look through
8 this more.

9 Q. Does it appear to be the amicus brief that
10 was submitted on your behalf in United States versus
11 Skrmetti, Case No. 23-477, in the Supreme Court of
12 the United States?

13 A. Yes.

14 Q. And you agree with everything stated in this
15 amicus brief?

16 A. I have not read this in a long time, so I
17 would have to look through this.

18 I am assuming if I signed off on it, yes.
19 But I have not read this in a while.

20 Q. Did you read it before it was filed?

21 A. I'm not sure of the timing, but I think so.

22 Q. What did you do to prepare for this
23 deposition?

24 A. I reread my report. I read the law that's
25 being -- that we are talking about in South Carolina.

1 Q. And did you review any other documents other
2 than your report and the law at issue?

3 A. No.

4 Q. And did you meet with --

5 Let me back up.

6 Without revealing any conversation with
7 counsel, did you meet with anyone in preparation for
8 today's deposition?

9 A. Yes.

10 Q. Who did you meet with?

11 A. These two people right here.

12 MR. SELDIN: I'll just note that it's
13 Harper Seldin and Aine Carolan, counsel for
14 plaintiffs.

15 THE WITNESS: And I think Sruti, too.

16 MR. RAMER: I'm sorry?

17 MR. SELDIN: And also --

18 Well, you testify.

19 THE WITNESS: And also Sruti, who's -- who's
20 on our video call.

21 BY MR. RAMER:

22 Q. Did you meet with anybody else other than
23 those three people to prepare for today's deposition?

24 A. No.

25 Q. All right. Sticking with Exhibit 6, which

1 is your amicus brief, I'd like to go to page 28 and
2 the last paragraph on the page.

3 And I'll read the first two sentences and
4 first ask if I've read them correctly.

5 It says:

6 "Instead, the review recognizes transgender
7 identity as real and states that gender-affirming
8 medical care is appropriate for certain transgender
9 youth before age 18.

10 "For example, the review notes that, 'for
11 some the best outcome will be transition,' while
12 also acknowledging as the WPATH Standards of Care in
13 the Endocrine Society Guidelines do, that
14 gender-affirming medical interventions are not
15 appropriate for all transgender adolescents."

16 Did I read that correctly?

17 A. Yes.

18 Q. And the review that's being discussed here
19 is the Cass, C-a-s-s, Review; correct?

20 A. That's correct.

21 Q. And in this part of the brief, the brief
22 suggests that the Cass Review says gender-affirming
23 medical care is appropriate for certain transgender
24 youth before age 18.

25 Correct?

1 A. Yes.

2 Q. Do you agree that science cannot currently
3 identify a specific biological basis for being
4 transgender or cisgender?

5 THE REPORTER: I'm sorry. Will you repeat
6 that, please.

7 MR. RAMER: I'll restart.

8 Q. Do you agree that science cannot currently
9 identify a specific biological basis for being
10 transgender or cisgender?

11 MR. SELDIN: Object to form.

12 THE WITNESS: Is there a biological marker?
13 Is that what you're asking?

14 BY MR. RAMER:

15 Q. Yes.

16 A. I agree.

17 Q. You agree with what part?

18 A. That there is not a biological marker that
19 we have discovered yet that can indicate if somebody
20 is cisgender or transgender.

21 Q. And relatedly, you agree that there is no
22 medical test that can be used to predict whether
23 someone will identify as cisgender or transgender;
24 correct?

25 MR. SELDIN: Object to form.

1 THE WITNESS: I think that's what I was
2 trying to say in the previous question.

3 BY MR. RAMER:

4 Q. And so you do agree there is no medical
5 test.

6 A. Correct.

7 Q. And you agree that the etiology of gender
8 and congruence is not fully understood; correct?

9 MR. SELDIN: Object to form.

10 THE WITNESS: Correct.

11 BY MR. RAMER:

12 Q. And the ratio of the patients in your clinic
13 has shifted from 50 percent natal males and
14 50 percent natal females in 2015 to about two-thirds
15 natal females now; correct?

16 MR. SELDIN: Object to form.

17 THE WITNESS: About two-thirds of my
18 practice in our clinic, in general, are people that
19 are designated female at birth.

20 BY MR. RAMER:

21 Q. And that is a shift that you've observed in
22 your time as a clinician from a 50 percent patient
23 mix; correct?

24 A. Correct.

25 Q. And was it about 2015 that you last recalled

1 the ratio being 50/50?

2 MR. SELDIN: Object to form.

3 THE WITNESS: I think that's when it
4 shifted.

5 BY MR. RAMER:

6 Q. And you agree that the rise in the number of
7 people who present with gender dysphoria is a trend
8 that we do not fully understand scientifically;
9 correct?

10 MR. SELDIN: Object to form and foundation.

11 THE WITNESS: I don't -- I don't necessarily
12 know that I understand what you're asking.

13 I think that there are observable reasons
14 why there are an increase in the numbers of people
15 who are designated female at birth that identify as
16 masculine, male.

17 BY MR. RAMER:

18 Q. And so you're talking about natal females or
19 female assigned at birth; correct?

20 A. Correct.

21 Q. And do you agree that we have seen a rise in
22 the number of people in that patient population who
23 present with gender dysphoria; correct?

24 A. Yes.

25 Q. And do you agree that we do not fully

1 understand why that number is rising?

2 MR. SELDIN: Object to form.

3 THE WITNESS: I -- I don't know if I know
4 how to answer your question.

5 There are reasons that we are seeing more
6 people in that ratio. Are they scientifically
7 proven?

8 No.

9 BY MR. RAMER:

10 Q. You agree that there can be times when an
11 adolescent receives a diagnosis for gender dysphoria
12 under the DSM-5, but the adolescent is not
13 transgender; correct?

14 MR. SELDIN: Object to form.

15 THE WITNESS: I agree that that could
16 happen, yes.

17 BY MR. RAMER:

18 Q. Do you agree that it has ever happened?

19 A. Yes.

20 Q. You agree that gender dysphoria shares
21 symptomatology with anxiety and depression; correct?

22 MR. SELDIN: Object to form.

23 THE WITNESS: Yes.

24 BY MR. RAMER:

25 Q. You do not view the DSM-5 as authoritative

1 with respect to the diagnosis of gender dysphoria;
2 correct?

3 MR. SELDIN: Object to form and foundation.

4 THE WITNESS: I would need more clarity on
5 that. I'm not sure.

6 The DSM is an authoritative text, and it
7 does have criteria for the diagnosis of gender
8 dysphoria.

9 BY MR. RAMER:

10 Q. Do you think that everything the DSM-5 says
11 about the diagnosis of gender dysphoria is accurate?

12 MR. SELDIN: Object to form.

13 THE WITNESS: I think that there are three
14 criteria in the DSM that are -- I have skepticism
15 about, because they have to do with very
16 stereotypical things that are not necessarily
17 applicable to humans in 2024.

18 MR. RAMER: I'm going to hand the court
19 reporter a document that I'll ask to be marked as
20 Olson-Kennedy Exhibit 7.

21 (Deposition Exhibit 7 was marked for
22 identification by the court reporter.)

23 BY MR. RAMER:

24 Q. And, Dr. Olson-Kennedy, you've been handed
25 what's been marked as Olson-Kennedy Exhibit 7.

1 And I will represent to you that this
2 exhibit is the cover of the DSM-5.

3 And then do you agree that part of it is
4 what appears to be the chapter from the DSM-5
5 regarding gender dysphoria?

6 A. Yes.

7 Q. And I'd like to go to the page that has 516
8 on it. It's about the fifth page into the exhibit.

9 Do you see that?

10 A. I do.

11 Q. And toward the bottom, there's a paragraph
12 that has percentages in it.

13 Do you see that?

14 A. I do.

15 Q. And the last sentence of that paragraph --
16 I'll read it and ask if I read it correctly.

17 It says:

18 "Early social transition may also be a
19 factor in persistence of gender dysphoria in
20 adolescence."

21 Did I read that correctly?

22 A. You did.

23 Q. And you disagree with the DSM-5 on that
24 issue; correct?

25 MR. SELDIN: Object to form. Foundation.

1 THE WITNESS: I think that the assumption of
2 the causality, the way that people talk about this
3 sentence is incorrect.

4 Do I think that social transition is a
5 factor?

6 Yes, I do.

7 BY MR. RAMER:

8 Q. During your deposition in Voe versus
9 Mansfield, when you were asked whether you agree with
10 that statement I just read, you said you do not;
11 correct?

12 A. The statement if its meaning early social
13 transition causes gender dysphoria in adolescence, I
14 do not agree with that.

15 Do I agree that it's a factor?

16 I do.

17 Q. What is the difference between something
18 being a factor and something being part of a cause?

19 A. I don't think that social transition in
20 childhood leads to a transgender identity in
21 adolescence.

22 I think that for the most part -- and again,
23 this is -- there's a lot of ways that social
24 transition is described historically and
25 contemporaneously -- I don't think that social

1 transition in childhood leads to a continued identity
2 as a cause of it.

3 I think that people who are socially
4 transitioned in childhood, the majority of them are
5 trans. And then that is why they continue to assert
6 a transgender identity in adolescence.

7 Q. And just to confirm -- because I'm -- I'm
8 not sure I heard an answer to this precise question.

9 But during your deposition in Voe versus
10 Mansfield, when you were asked whether you agree with
11 this statement, you said you do not; correct?

12 MR. SELDIN: I object to form. Foundation.

13 THE WITNESS: I think that the way the --
14 the -- there's -- the way that this is -- this
15 sentence is perceived and it's the way that it's
16 exactly written.

17 So the way the sentence is written is the
18 flavor of it is that early social transition may be a
19 cause in the persistence of gender dysphoria in
20 adolescence.

21 I agree that it's a factor, in that it is
22 related. But is it a cause of persistence? I think
23 that that is the flavor of what this document is
24 saying, and that I do not agree with.

25 ///

1 BY MR. RAMER:

2 Q. And can you go to Olson-Kennedy Exhibit 4,
3 which is your deposition transcript from Voe versus
4 Mansfield. And specifically go to page 62.

5 A. 62 is like the little numbers?

6 Q. Correct.

7 A. Okay.

8 Q. And beginning at line 8 --

9 A. Yes.

10 Q. -- you see you were asked about this
11 particular sentence. And at line 13, you are asked,
12 do you agree with that statement?

13 And at line 14, you answered "I do not."

14 Correct?

15 A. Correct.

16 Q. And, Dr. Olson-Kennedy, you are not aware of
17 any study that looks at the desistance rate among
18 adolescence who do not receive puberty blockers;
19 correct?

20 MR. SELDIN: Object to form.

21 THE WITNESS: Oh, my gosh. Can you --
22 that's a lot of things in that sentence.

23 Can we go back? Could you say it slower?

24 BY MR. RAMER:

25 Q. Absolutely.

1 You were not aware of any study that looks
2 at the desistance rate among adolescents who do not
3 receive puberty blockers; correct?

4 A. Correct.

5 MR. SELDIN: Object to form.

6 THE WITNESS: Correct.

7 BY MR. RAMER:

8 Q. And have any studies demonstrated that
9 gender affirmation in childhood does not lead to a
10 child being transgender who otherwise might not have
11 been transgender?

12 MR. SELDIN: Object to form.

13 THE WITNESS: One more time.

14 BY MR. RAMER:

15 Q. Have any studies demonstrated that gender
16 affirmation in childhood does not lead to a child
17 being transgender who otherwise might not have been
18 transgender?

19 MR. SELDIN: Same objection.

20 THE WITNESS: Can you describe what you mean
21 by "gender affirmation" here?

22 BY MR. RAMER:

23 Q. Social transition.

24 A. So complete social transition or a partial
25 social transition?

1 Q. Can you explain the distinction you're
2 drawing?

3 A. Sure.

4 So when social transition first started
5 being described in the Netherlands, they made a
6 distinction between a partial and a complete social
7 transition.

8 So, in other words, children who changed
9 things like their hair and their clothing were
10 considered to be partially socially transitioned.
11 And children who had changed their name, their
12 pronouns and their clothing and potentially other
13 things, like their hair and things like that, were
14 complete -- considered to be completely socially
15 transitioned.

16 Q. Let's take any understanding of social
17 transition along the lines you just described.

18 Have any studies demonstrated that social
19 transition in childhood does not lead to a child
20 being transgender who otherwise might not have been?

21 MR. SELDIN: Object to form.

22 THE WITNESS: The -- no. I think -- I think
23 that I understand all of the --

24 What I can tell you is that there are people
25 who are socially transitioned in childhood who do not

1 continue to have a transgender identity, both
2 personally in my clinic and also from the work by
3 Christina Olson.

4 But I think specifically what you're talking
5 about, I don't think I've seen a study like that.

6 BY MR. RAMER:

7 Q. And I think you've already touched on this,
8 but you think that some of the diagnostic criteria in
9 the DSM-5 are outdated.

10 Correct?

11 MR. SELDIN: Object to form. Foundation.

12 THE WITNESS: Just for clarity, do you mean
13 the diagnosis in adolescence? In adulthood or in
14 childhood?

15 BY MR. RAMER:

16 Q. Let's start with childhood.

17 A. Yes.

18 Q. And so let's return to Olson-Kennedy
19 Exhibit 7.

20 And on -- the third page of the document has
21 a 512 number, is the beginning of the diagnostic
22 criteria for gender dysphoria in children; correct?

23 A. Yes.

24 Q. And starting with A-6 on this page, you
25 agree that this criterion is outdated; correct?

1 MR. SELDIN: Object to form. Foundation.

2 THE WITNESS: I do.

3 BY MR. RAMER:

4 Q. And it's outdated because it requires
5 stereotyping, clothing, toys and games by gender;
6 correct?

7 MR. SELDIN: Object to form.

8 THE WITNESS: Yes.

9 BY MR. RAMER:

10 Q. And criterion A-2, that also requires
11 stereotyping clothing; correct?

12 A. It does.

13 Q. And criterion A-3 requires stereotyping
14 roles in make-believe or fantasy play; correct?

15 MR. SELDIN: Object to form.

16 THE WITNESS: Yes.

17 BY MR. RAMER:

18 Q. And criterion A-4 requires stereotyping
19 toys, games and activities; correct?

20 MR. SELDIN: Object to form.

21 THE WITNESS: Yes. But at least that's
22 written in the actual sentence. Yes.

23 BY MR. RAMER:

24 Q. When you say "it," you're referring to the
25 word stereotypically?

1 A. Correct.

2 Q. And so these criteria we just discussed are
3 outdated as well; correct?

4 MR. SELDIN: Object to form.

5 THE WITNESS: Yes.

6 BY MR. RAMER:

7 Q. And as part of your practice, you sometimes
8 diagnose gender dysphoria in children; correct?

9 A. Not usually. In prepubertal children, I
10 will most often use a different diagnostic code than
11 gender dysphoria.

12 Q. What diagnostic code do you use?

13 A. I use gender identity uncertainty.
14 Sometimes I will use a code that is called "Worried
15 Well." So that means a family comes in with a lot of
16 questions, but there's -- there's not really anything
17 medically concerning with that young person.

18 So in most children, they're prepubertal,
19 that is the diagnosis I use.

20 Q. And did you say worried well as in
21 W-o-r-r-i-e-d Well?

22 A. W-e-l-l, yes.

23 Q. Thank you.

24 Have you ever diagnosed a patient with
25 gender dysphoria in childhood?

1 A. I have.

2 Q. And to do that, you are required to
3 stereotype at least some clothing, toys or
4 activities; correct?

5 MR. SELDIN: Object to form.

6 THE WITNESS: That's correct.

7 I would like to give some context to that.
8 I started doing this work 18 years ago, and it was
9 before I had really started thinking a lot about
10 these things that are in the diagnostic criteria in a
11 very critical way or thinking about the stereotyping,
12 because over the last 18 years, it's changed a lot.

13 I think we see, for example, like, Target,
14 there's much less division of clothes. There's much
15 less division of toys. And I think that's been a
16 shift over time in our society.

17 I think 18 years ago, there was a lot of
18 distinction here.

19 So I would say that my utilizing this code
20 over time has changed.

21 BY MR. RAMER:

22 Q. When you say "Target," are you referring to
23 the store?

24 A. I am referring to the store.

25 Q. And what do you think the diagnostic

1 criteria should be?

2 MR. SELDIN: Object to form.

3 THE WITNESS: I think that the diagnostic
4 criteria should be gender incongruence. That's the
5 first part.

6 I think that the utility of a diagnosis of
7 gender dysphoria in prepubertal children is not
8 necessary, necessarily.

9 I have not spent a lot of time thinking
10 about that because that is a very small number of
11 people that I see in my practice.

12 BY MR. RAMER:

13 Q. And the diagnostic criteria for gender
14 incongruence does not require the presence of
15 distress; correct?

16 MR. SELDIN: Object to form.

17 THE WITNESS: That's correct. That's my
18 understanding of it. We don't use that in the
19 United States.

20 BY MR. RAMER:

21 Q. But you think that should be the diagnosis
22 that is used for children; correct?

23 MR. SELDIN: Object to form.

24 THE WITNESS: I think this is more
25 complicated. I have thought sometimes that there

1 shouldn't be this diagnosis at all in children.

2 I think that there are some children that
3 experience distress.

4 But my observation has been that young --
5 young children who are talking about their gender,
6 who have their gender acknowledged and have gender
7 affirmation, depending -- well, what we talked about
8 a spectrum, oh, you can wear dresses at home or you
9 can wear them outside or you can use a different
10 name.

11 It is the case that a lot of people no
12 longer experience that distress after those things
13 have happened. And their distress reemerges when
14 they start puberty.

15 So I -- I don't know what you call that.
16 You call that a functioning person who maybe uses a
17 different name and pronouns. But I don't -- I don't
18 know that these criteria are necessary or necessarily
19 relevant during that time.

20 I think that there should be -- ideally,
21 there should be a code that says somebody has a
22 gender that's different than their assigned sex at
23 birth.

24 And that medical code then translates to any
25 potential interventions, but it also derails the

1 coupling of medical procedures that have to do with
2 body parts.

3 For example, if somebody changes -- if
4 somebody is assigned female at birth and they change
5 their gender marker to male, and then they go for
6 cervical screening, the insurance may not cover that
7 because the gender marker is different from the body
8 part, if that makes sense.

9 That's how I think it should be.

10 BY MR. RAMER:

11 Q. Is the answer the same for adolescents who
12 are gender incongruent?

13 MR. SELDIN: Object to form.

14 THE WITNESS: No.

15 BY MR. RAMER:

16 Q. Why is it different?

17 A. The criteria for gender dysphoria in -- in
18 adolescence is much more about bodies. And this is
19 one of the reasons you only have to meet two of the
20 criteria in adolescence and adulthood. Because that
21 diagnosis is primarily concerned with what you might
22 do for medical intervention.

23 Q. Do you think that the presence of distress
24 should be required?

25 MR. SELDIN: Object to form.

1 THE WITNESS: For a diagnosis of gender
2 dysphoria?

3 BY MR. RAMER:

4 Q. In adolescence. Correct.

5 A. Yes. Yes, I do.

6 Q. And why?

7 A. Because "dysphoria" means distress. And so
8 if you just are trans and you don't have gender
9 dysphoria, that's what I'm talking about. You
10 need -- there needs to be a medical code that allows
11 you to continue care with somebody even if they
12 aren't experiencing distress anymore.

13 And usually people who are not experiencing
14 stress are not coming for medical interventions.
15 They're coming for medical interventions because of
16 their distress, for the most part.

17 Q. And so in that answer you said "usually" and
18 "for the most part."

19 And so is it accurate to say that it is not
20 always the case that those seeking medical
21 interventions are suffering from distress?

22 MR. SELDIN: Object to form.

23 THE WITNESS: I think it largely depends how
24 you describe distress.

25 Do I think that there are people who are

1 coming for medical interventions for no reason
2 whatsoever? No.

3 They're coming because there is a missing or
4 a misalignment between their gender and their
5 physicality. That's why they're coming.

6 That tension in and of itself is distressing
7 for people.

8 Does it cause functional impairment? I
9 don't think we ever know, because we don't know what
10 it would have been like for them to be cisgender. So
11 we don't really know how they would function
12 otherwise.

13 My own interpretation is that -- and I --
14 the reason I say this is I know there are trans
15 people who do not have gender dysphoria. But the
16 people coming to see me for medical intervention have
17 distress.

18 BY MR. RAMER:

19 Q. And so there could never be a patient who is
20 gender incongruent but is not suffering from distress
21 as the DSM-5 discusses it; correct?

22 MR. SELDIN: Object to form. Foundation.
23 Misstates testimony.

24 THE WITNESS: I think the problem with the
25 DSM is that clinically significant distress is not

1 defined.

2 And so, yes, there's a possibility that
3 anybody could come -- there's infinite possibilities
4 in medicine. There -- always there are as many
5 possibilities as there are humans.

6 I think the challenge is that clinically
7 significant distress is not really defined in the
8 DSM.

9 BY MR. RAMER:

10 Q. So is the requirement of clinically
11 significant stress superfluous then?

12 MR. SELDIN: Object to form. Misstates
13 testimony.

14 THE WITNESS: No. It's not superfluous.
15 It's just not defined.

16 BY MR. RAMER:

17 Q. But you agree that somebody can be --
18 Let me back up.

19 You agree that being gender incongruent, in
20 and of itself, is distressful; correct?

21 MR. SELDIN: Object to form. Misstates
22 testimony.

23 THE WITNESS: I think there are people who
24 are gender incongruent who are not distressed.
25 ///

1 BY MR. RAMER:

2 Q. And those people --

3 Let me back up.

4 For that category of patients, it would be
5 inappropriate to give them any form of medical
6 intervention; correct?

7 MR. SELDIN: Object to form. Foundation.

8 THE WITNESS: I think that if people are
9 not -- I think that if people are seeking medical
10 intervention, they have distress.

11 BY MR. RAMER:

12 Q. And so nobody who is gender incongruent but
13 not distressed within the meaning of DSM-5, would
14 ever seek a medical intervention.

15 Is that what you're saying?

16 MR. SELDIN: Object to form. Foundation.
17 Misstates testimony.

18 THE WITNESS: And this goes back to what I
19 was saying, is that: What does "clinically
20 significantly distressed" mean? What is clinical --
21 significantly clinically depressed? I mean
22 distressed.

23 I don't know that clinically significant
24 stress or impairment is not defined in the DSM. This
25 is a very commonly used phrase across the entire DSM,

1 and it's not defined.

2 BY MR. RAMER:

3 Q. How do you make a diagnosis under the DSM if
4 you don't know what it means?

5 MR. SELDIN: Object to form. Misstates
6 testimony.

7 THE WITNESS: I know what distress means.

8 But as it's defined here, "clinically
9 significant," the DSM does not define that. The
10 people that I see have distress. That's how I define
11 it.

12 And when people have distress, they meet the
13 criteria.

14 BY MR. RAMER:

15 Q. And you know they have distress because they
16 are seeking medical intervention; is that right?

17 MR. SELDIN: Object to form. Misstates
18 testimony.

19 THE WITNESS: No.

20 I know that they have distress because I
21 have long conversations with people.

22 BY MR. RAMER:

23 Q. And what is the product of those long
24 conversations?

25 MR. SELDIN: Object to form.

1 THE WITNESS: Sometimes the product of those
2 long conversations is -- well, all the time actually,
3 is understanding the areas that are distressful for
4 people.

5 Sometimes the conversation is what is it
6 that you're seeking from medical intervention?

7 Will medical intervention get you there?

8 Will it not do the things that you are seeking?

9 On the conversation span, a whole range of
10 topics.

11 The product of a conversation is
12 information.

13 BY MR. RAMER:

14 Q. If a patient has an embodiment goal --
15 e-m-b-o-d-i-m-e-n-t -- and their body is not
16 presently aligned with that embodiment goal, is that
17 patient necessarily distressed?

18 MR. SELDIN: Object to form.

19 THE WITNESS: I think so, yes.

20 BY MR. RAMER:

21 Q. Switching gears just a little bit to
22 international consensus.

23 Do you agree that the policies on
24 gender-affirming care in England, Sweden, Finland,
25 Australia and New Zealand, are more and more out of

1 step with the WPATH Standards of Care 8? Correct?

2 MR. SELDIN: Object to form. Foundation.

3 THE WITNESS: I think that -- I can't answer
4 about New Zealand and Australia. I'm not very
5 familiar with those protocols.

6 But the things that I have read, and I think
7 it's really important to distinguish this, that the
8 providers of care are not the same people as those
9 people who are publishing their thoughts and feelings
10 and recommendations about the care.

11 I think that there is a separation of those
12 two entities, and that's really important. Because
13 when you talk about consensus, are we talking about
14 clinician consensus? Or are we talking about report
15 consensus?

16 BY MR. RAMER:

17 Q. During your deposition in Voe versus
18 Mansfield, when you were asked whether the policies
19 on gender-affirming care in England, Sweden, Finland,
20 Australia and New Zealand, are more and more out of
21 step with WPATH Standards of Care 8, you said yes;
22 correct?

23 MR. SELDIN: Object to form. Foundation.

24 THE WITNESS: Yes.

25 MR. RAMER: The policies. I just want to

1 have real clarity about that.

2 Q. And you do not know whether any adolescents
3 with gender dysphoria in Sweden are currently
4 obtaining gender-affirming care through a research
5 protocol; correct?

6 MR. SELDIN: Object to form.

7 THE WITNESS: Correct.

8 BY MR. RAMER:

9 Q. You agree that the United Kingdom has in
10 fact banned the use of puberty blockers; correct?

11 MR. SELDIN: Object to form.

12 THE WITNESS: I do believe that I know that
13 now.

14 BY MR. RAMER:

15 Q. And going to Olson-Kennedy Exhibit 6, which
16 is your amicus brief, I'd like to go to page 9.

17 A. I just want to go back to this and say I've
18 never seen it in this format before. But I recognize
19 this is the paper that we wrote about the
20 Cass Review, yes.

21 Q. Just to confirm, this is not just a
22 copy-and-paste from your paper; correct?

23 A. No. There's additional -- there's
24 additional information. Yes.

25 But I recognize these words.

1 Q. And just so we're all on the same page,
2 let's go to page 5 of this brief first and look at
3 footnote 3.

4 And that footnote explains that there's
5 additional information in your paper that is not in
6 this brief; correct?

7 A. Correct.

8 Q. Okay. Now, going to page 9. And the very
9 last paragraph that carries over onto page 10, if you
10 could just take a moment to read that, and let me
11 know when you've read it.

12 MR. SELDIN: Mr. Ramer, are you talking
13 about the paragraph that starts, "Notably the Cass
14 Review"?

15 MR. RAMER: That's correct.

16 (Reporter clarification.)

17 MR. RAMER: Counsel -- counsel was
18 confirming with me whether the paragraph that I've
19 asked Dr. Olson-Kennedy to read is the one that
20 begins with the phrase "Notably the Cass Review."

21 And I said yes.

22 THE WITNESS: Yes. I'm done reading that.

23 BY MR. RAMER:

24 Q. And on page 10, in the final sentence of
25 that paragraph, the brief states that the

1 British Medical Association has called for a pause on
2 the U.K. ban on puberty blockers; correct?

3 A. Yes.

4 Q. And that sentence is no longer accurate, is
5 it?

6 MR. SELDIN: Object to form. Foundation.

7 THE WITNESS: I don't know.

8 MR. RAMER: I'm handing the court reporter
9 what I'll ask to be marked as Olson-Kennedy
10 Exhibit 8.

11 (Deposition Exhibit 8 was marked for
12 identification by the court reporter.)

13 THE WITNESS: I think this is the wrong
14 thing. It's just that single page.

15 BY MR. RAMER:

16 Q. And, Dr. Olson-Kennedy, you've been handed
17 what's been marked as Olson-Kennedy Exhibit 8; is
18 that correct?

19 A. Yes.

20 Q. And this appears to be a report published in
21 the BMJ; correct?

22 MR. SELDIN: Mr. Ramer, I would just like to
23 note that I don't believe that this was one of the
24 exhibits that you had noted in our correspondence you
25 intended to use.

1 So if we could just have a moment to read.
2 We don't need to leave the room, but it would be
3 helpful.

4 MR. RAMER: We'll go off the record.

5 MR. SELDIN: Thank you.

6 THE VIDEOGRAPHER: The time now is 10:36
7 a.m.

8 We are off the record.

9 (Off record.)

10 MR. RAMER: We'll go back on.

11 THE VIDEOGRAPHER: The time is 10:37 a.m.

12 We are back on the record.

13 BY MR. RAMER:

14 Q. And, Dr. Olson-Kennedy, the document that's
15 been marked as Olson-Kennedy Exhibit 8 is a report
16 published in the British Medical Journal; correct?

17 MR. SELDIN: Object to form.

18 THE WITNESS: That is what it looks like.

19 BY MR. RAMER:

20 Q. And the first sentence of this document,
21 I'll read it and ask if I read it correctly, says:

22 "The BMA has retracted its call for the U.K.
23 government to lift the ban on prescribing puberty
24 blockers to under 18s with gender dysphoria while the
25 association conducts an evaluation of the Cass

1 Review's recommendations."

2 Did I read that correctly?

3 A. Yes.

4 Q. And so returning to Exhibit 6, which is your
5 amicus brief, and page 10 in the final sentence of
6 the carry-over paragraph from page 9.

7 According to the report that we just read,
8 that sentence is incorrect; right?

9 MR. SELDIN: Object to form.

10 THE WITNESS: I guess I'm not understanding
11 the question at the time that this was prepared, that
12 is correct.

13 That has the BMA retracted, that's called,
14 yes.

15 BY MR. RAMER:

16 Q. And was this deposition the first that you
17 became aware of the BMA retracting that call?

18 A. Yes.

19 Q. And do you think that you should correct the
20 statement made on your behalf to the Supreme Court of
21 the United States?

22 MR. SELDIN: Object to form.

23 THE WITNESS: I don't know the answer to
24 that.

25 Yes. I mean, we want it to be accurate, of

1 course.

2 MR. RAMER: And I'm at a point where it's
3 kind of a good stopping point.

4 If this works for you, I'll take a short
5 little break. Does that work for you?

6 THE WITNESS: Sure. Yeah.

7 MR. RAMER: Go off.

8 THE VIDEOGRAPHER: The time now is 10:39
9 a.m.

10 We're now off the record.

11 (Short recess.)

12 MR. RAMER: Ready.

13 THE VIDEOGRAPHER: One moment, please.

14 The time is 10:52 a.m., and we're back on
15 the record.

16 BY MR. RAMER:

17 Q. Welcome back, Doctor.

18 A. Thank you.

19 MR. RAMER: I'm going to hand the court
20 reporter what I'll ask to be marked as Olson-Kennedy
21 Exhibit 9.

22 (Deposition Exhibit 9 was marked for
23 identification by the court reporter.)

24 THE WITNESS: Thank you.

25 ///

1 BY MR. RAMER:

2 Q. And, Dr. Olson-Kennedy, you've been handed
3 what's been marked as Olson-Kennedy Exhibit 9.

4 And these are the Informed Consent forms
5 used for patients receiving treatment at Children's
6 Hospital of Los Angeles; correct?

7 A. The first part of these are a consent and
8 assent forms for participating in a study.

9 The second part of this packet has consent
10 forms for medical interventions.

11 Q. And when you say "the second part of the
12 packet," can you direct me to what page you're
13 talking about?

14 A. The first one is the Informed Consent for --
15 form for feminizing medications. That's the
16 beginning of the clinical consent form.

17 These are not part of the study.

18 Q. Thank you.

19 And beginning with these Clinical Consent
20 forms, these are either the forms that you're using
21 today or are extremely close to what you're using
22 today; correct?

23 MR. SELDIN: Object to form.

24 THE WITNESS: Yes.

25 ///

1 BY MR. RAMER:

2 Q. And this first one, which is labeled
3 "Informed Consent Form for Feminizing Medications,"
4 parenthesis, "(transfeminine individuals on GnRH
5 Analogs)," this form would be used for natal males
6 who either had their endogenous --
7 e-n-d-o-g-e-n-o-u-s -- puberty blocked or who had not
8 yet experienced male pubertal development; correct?

9 A. Or were in their -- we would not be giving
10 hormones to somebody who had not yet started puberty
11 but if they were in early puberty.

12 Q. And so the answer to the question was yes,
13 and also for those who have not had a significant
14 amount of male pubertal development; is that right?

15 MR. SELDIN: Object to form. Misstates
16 testimony.

17 THE WITNESS: This form is for people who
18 either had GnRH analogs that were started in early
19 puberty or people who are starting hormones who have
20 not yet experienced a lot of their puberty.

21 BY MR. RAMER:

22 Q. Thank you.

23 And to your knowledge, this consent form is
24 accurate in its description of the risks of
25 feminizing medications; correct?

1 A. Yes.

2 Q. And so on this page down at No. 5, you agree
3 that a person who begins taking puberty blockers in
4 early puberty and then proceeds to feminizing
5 hormones will be infertile; correct?

6 MR. SELDIN: Object to form.

7 THE WITNESS: This is why the word "likely"
8 is in there.

9 BY MR. RAMER:

10 Q. And so is the answer yes?

11 A. They are likely to be infertile.

12 Q. And you agree that if a person is on puberty
13 blockers in early puberty and they stay on feminizing
14 hormones, they will not make mature sperm; correct?

15 A. Yes. If they stay on those interventions.

16 Q. Thank you.

17 Going to the next page, No. 6, you agree
18 that feminizing medications increase the risk of
19 blood clots; correct?

20 MR. SELDIN: Object to form.

21 THE WITNESS: Minimally, yes.

22 BY MR. RAMER:

23 Q. And you agree that feminizing medications
24 increase the risk of a pulmonary embolism; correct?

25 MR. SELDIN: Object to form.

1 THE WITNESS: Yes.

2 BY MR. RAMER:

3 Q. And a pulmonary embolism is a blood clot to
4 the lungs; correct?

5 A. That's correct.

6 Q. And a pulmonary embolism can cause permanent
7 lung damage or death; correct?

8 A. Correct.

9 Q. And then second bullet under 6, you agree
10 that feminizing medications increase the risk of
11 stroke; correct?

12 MR. SELDIN: Object to form.

13 THE WITNESS: These are the potential things
14 that can happen when somebody gets a blood clot.

15 MR. SELDIN: Mr. Ramer, I apologize for
16 interrupting.

17 The screen that has the Zoom appears to be
18 off. I wasn't sure --

19 MR. RAMER: It's -- want to go off?

20 MR. SELDIN: Yeah.

21 THE WITNESS: Oh, yeah.

22 THE VIDEOGRAPHER: The time is 10:58 a.m.
23 We're off the record.

24 (Off record.)

25 THE VIDEOGRAPHER: Let me know when you're

1 ready.

2 MR. SELDIN: Doctor, are you ready?

3 THE WITNESS: Yes. I'm ready.

4 THE VIDEOGRAPHER: The time is 11:03 a.m.,
5 and we are back on the record.

6 BY MR. RAMER:

7 Q. Okay. Doctor, we are on Olson-Kennedy
8 Exhibit 9. And we were looking at the second page of
9 the Informed Consent form for feminizing medications
10 for transfeminine individuals on GnRH analogs.

11 And we were looking at No. 6 on page 2 of
12 that form. And we were on, I believe, the second
13 bullet.

14 And my question is: You agree that
15 feminizing medications increase the risk of stroke;
16 correct?

17 MR. SELDIN: Object to form.

18 THE WITNESS: Estrogen increases the risk of
19 blood clots. I have never seen a study that looked
20 at the incidence of any of these things, pulmonary
21 emboli, stroke, heart attack or chronic leg vein
22 problems.

23 BY MR. RAMER:

24 Q. You agree that blood clots can result in
25 stroke; correct?

1 A. Yes.

2 Q. And you agree that a stroke may cause
3 permanent brain damage or death; correct?

4 A. Yes.

5 Q. And next bullet, you agree that feminizing
6 medications increase the risk of heart attack;
7 correct?

8 MR. SELDIN: Object to form.

9 THE WITNESS: Feminizing hormones increase
10 the risk of blood clots, which could potentially lead
11 to a heart attack, yes.

12 BY MR. RAMER:

13 Q. And the next bullet, you agree that
14 feminizing medications increase the risk of chronic
15 leg vein problems; correct?

16 MR. SELDIN: Object to form.

17 THE WITNESS: Same issue. That estrogen
18 specifically -- and I think this is important --
19 increases the risk of blood clots minimally which can
20 lead to chronic leg vein problems.

21 BY MR. RAMER:

22 Q. Is it fair to say that a pulmonary embolism,
23 a stroke or a heart attack is detrimental to people's
24 physical health?

25 A. Yes.

1 Q. And same page, No. 7, further down the page,
2 the second bullet under No. 7. You agree that
3 feminizing medications can lead to increased blood
4 pressure; correct?

5 MR. SELDIN: Object to form.

6 THE WITNESS: Yes.

7 BY MR. RAMER:

8 Q. And next bullet, you agree that feminizing
9 medications can lead to increased risk of gallstones;
10 correct?

11 MR. SELDIN: Object to form.

12 THE WITNESS: Yes.

13 BY MR. RAMER:

14 Q. And next bullet, you agree that feminizing
15 medications can lead to nausea and vomiting; correct?

16 MR. SELDIN: Object to form.

17 THE WITNESS: Yes.

18 BY MR. RAMER:

19 Q. And next bullet, you agree that feminizing
20 medications can lead to headaches and migraines;
21 correct?

22 MR. SELDIN: Object to form.

23 THE WITNESS: Correct.

24 BY MR. RAMER:

25 Q. Same page, No. 8. You agree that feminizing

1 medications can cause tumors of the pituitary gland;
2 correct?

3 MR. SELDIN: Object to form.

4 THE WITNESS: Correct.

5 BY MR. RAMER:

6 Q. And those tumors can damage vision and cause
7 headaches; correct?

8 MR. SELDIN: Object to form.

9 THE WITNESS: Correct.

10 BY MR. RAMER:

11 Q. And so let's go two pages forward in
12 Olson-Kennedy Exhibit 9.

13 And at the top, it says "Informed Consent
14 Form for Feminizing Medications"; correct?

15 A. Correct.

16 Q. And this is the Informed Consent Form for
17 Feminizing Medications when used with natal males who
18 either are well into male puberty or have gone
19 through male puberty; correct?

20 MR. SELDIN: Object to form.

21 THE WITNESS: Correct.

22 Sorry.

23 MR. SELDIN: I object to form.

24 You can answer.

25 THE WITNESS: Correct.

1 BY MR. RAMER:

2 Q. And does this form accurately -- excuse me.

3 Does this form accurately describe the risks
4 of feminizing medication?

5 A. I have to go through it again, but yes,
6 basically.

7 We've changed some of our recommendations
8 based on our findings, particularly around
9 prolactinomas, which is bullet number --

10 9. It's No. 9, not bullet point.

11 Q. And what have you changed?

12 A. We haven't changed it on our form yet. But
13 they're -- we have not seen that. And there have
14 been a couple of studies I think that have
15 demonstrated that this is no longer a finding.

16 Q. What are those studies?

17 A. I can't remember them offhand. One of them
18 came from our team, the one that -- I think it's the
19 last one on my CV.

20 Q. Apart from the number about prolactinomas,
21 does, this form accurately describe the risks of
22 feminizing medication?

23 A. Yes.

24 Q. And after this form, there's a form with the
25 title "Pubertal Blockers for Minors in Early

1 Adolescence."

2 Do you see that?

3 A. I do.

4 Q. And this is the form you would use for
5 people starting puberty blockers in early
6 adolescence; correct?

7 A. This is the form that we would use for
8 anybody going on to puberty blockers at any point in
9 their development.

10 Q. And in what scenario would you give somebody
11 who is not in early adolescence, puberty blockers?

12 MR. SELDIN: Object to form. Misstates
13 testimony.

14 THE WITNESS: Sometimes puberty blockers are
15 used for just halting further development.

16 So, for example, if somebody was in maybe
17 Tanner Stage 4 and they didn't want to get additional
18 breast development and they wanted to stop having a
19 period, that they could go on puberty blockers for
20 those purposes.

21 BY MR. RAMER:

22 Q. So why would you not just use the cross-sex
23 hormone for somebody at Tanner Stage 4?

24 A. That's -- they're not at that place where
25 they want that yet. That's not what they need in

1 that moment. They want to take a pause and not have
2 additional development. But they're not necessarily
3 wanting or ready for moving forward, or their parents
4 not -- might not be ready.

5 Q. And when you say "that's not what they
6 need," that need is based on the patient's embodiment
7 goals; correct?

8 MR. SELDIN: Object to form.

9 THE WITNESS: Correct.

10 BY MR. RAMER:

11 Q. Sticking with this form, next page, down
12 below the bold "Risks of Puberty Blockers," do you
13 see that?

14 A. I do.

15 Q. And looking at the first bullet, you agree
16 that the side effects and safety of puberty blockers
17 are not completely understood; correct?

18 A. That's correct.

19 Q. And you do not know whether delaying puberty
20 in an adolescent changes the adolescent's brain
21 development; correct?

22 MR. SELDIN: Object to form.

23 THE WITNESS: That's correct.

24 BY MR. RAMER:

25 Q. And you agree that we do not have scientific

1 evidence about how pubertal suppression affects young
2 people's judgment in decision-making; correct?

3 MR. SELDIN: Object to form.

4 THE WITNESS: Only clinical experience.

5 BY MR. RAMER:

6 Q. And so we do not have scientific evidence
7 about how puberty suppression affects young people's
8 judgment in decision-making; correct?

9 MR. SELDIN: Object to form. Asked and
10 answered.

11 THE WITNESS: That's correct.

12 BY MR. RAMER:

13 Q. And going forward three pages, there's a
14 form with the title "Informed Consent Form for
15 Testosterone Therapy."

16 Do you see that?

17 A. Yes.

18 Q. And on this page, No. 3, the first sentence
19 says: "It is not known what the effects of
20 testosterone are on fertility"; correct?

21 A. Yes.

22 Q. And if a natal female begins taking
23 masculinizing hormones and later stops them, we don't
24 know whether that person will regain the ability to
25 be fertile; correct?

MR. SELDIN: Object to form.

THE WITNESS: We don't know that. But I think it's important to add that we didn't really know their fertility status before they started.

And we also know that there are a lot of people who have stopped testosterone and carried pregnancies or harvested eggs.

BY MR. RAMER:

Q. When you say we don't know their fertility status before we started, what do you mean by that?

A. That person could have not had the capacity to get fertile. I mean, they -- we don't know what their capacity would've been to get pregnant at all.

Q. Is that something that you assess in your patients?

A. No.

Q. And sticking with this page -- I'm sorry -- next page, under "Risks of Testosterone," the first bullet under that, you agree that masculinizing medications can increase the risk of heart disease; correct?

A. Yes.

Q. And on this page after that bullet, there are three bullets. Then there's a paragraph, and then there's another bullet that begins with the

phrase "Increase the red blood cells."

Do you see that?

A. I do.

Q. And you agree that masculinizing medications increase the risk of stroke and heart attack; correct?

MR. SELDIN: Object to form.

THE WITNESS: Yes.

BY MR. RAMER:

Q. And next bullet, you agree that masculinizing hormones increase the risk of diabetes; correct?

MR. SELDIN: Object to form.

THE WITNESS: Yes.

BY MR. RAMER:

Q. And next bullet, you agree that masculinizing hormones can risk the HIV; correct?

MR. SELDIN: Object to form.

THE WITNESS: Yes.

BY MR. RAMER:

Q. And next bullet, you agree that masculinizing hormones can cause headaches or migraines; correct?

MR. SELDIN: Object to form.

THE WITNESS: Yes.

BY MR. RAMER:

Q. And next bullet, you agree that masculinizing hormones can lead to increased anger; correct?

MR. SELDIN: Object to form.

THE WITNESS: Yes.

BY MR. RAMER:

Q. Is it fair to say that heart disease, diabetes and HIV are detrimental to people's physical health?

A. Yes.

Q. And two pages later, there's a document entitled "Informed Consent Form for Testosterone Therapy," parenthesis, "(for Youth on GnRH Analogs)."

Do you see that?

A. Yes.

Q. And this form is used for young people who have not been through endogenous female puberty; correct?

A. Correct.

Q. And on the next page, there's the bold, entitled "Risks of Testosterone."

Do you see that?

A. Yes.

Q. And do you agree that this form is accurate

in describing the effects and risks of testosterone therapy for this population?

A. Similar to the Prolactin, that first bullet point about liver damage, there have also been -- and I can't tell you the exact papers -- but there -- that particular thing has been put to rest about liver disease.

Q. And just so I understand your -- what you're saying, you're saying that Prolactinomas and liver disease have been --

Let me back up.

You're saying that masculinizing hormones in this context have been proven to not increase the risk of liver disease; is that right?

A. There have been several manuscripts that have said testosterone does not lead to increasing liver enzymes.

Q. And you're confident enough in those studies that you're going to be removing that from your Informed Consent forms?

A. In my clinical practice, yes.

Q. And apart from liver disease with this form, is the form accurate in describing the effects and risks of testosterone therapy for this population?

A. Yes.

1 Q. And given all the risks that we just
2 discussed, you would agree that these medications are
3 not safe; correct?

4 MR. SELDIN: Object to form. Misstates
5 testimony.

6 THE WITNESS: No.

7 BY MR. RAMER:

8 Q. But we discussed that these side effects are
9 detrimental to people's physical health; correct?

10 MR. SELDIN: Object to form.

11 THE WITNESS: Correct.

12 BY MR. RAMER:

13 Q. And when you were deposed in Voe versus
14 Mansfield, you explained that when you say
15 medications are safe, you mean that they are not
16 detrimental to people's physical health; correct?

17 A. All medications have potential side effects.
18 They happen to be listed more explicitly in these
19 consent forms.

20 Q. In your deposition in Voe versus Mansfield,
21 when you were asked what you meant by saying that
22 these interventions were safe, you said it means that
23 they have not been demonstrated to be detrimental to
24 people's physical health; correct?

25 MR. SELDIN: Objection. Foundation.

1 THE WITNESS: Correct.

2 BY MR. RAMER:

3 Q. And here, we've just discussed all these
4 increased risks of conditions that are detrimental to
5 people's physical health; correct?

6 A. Correct.

7 Q. And so using your definition of what it
8 means for medications to be safe, these medications
9 are not safe; correct?

10 MR. SELDIN: Object to form. Misstates
11 testimony. Asked and answered.

12 THE WITNESS: Same answer as before.

13 BY MR. RAMER:

14 Q. Which was what?

15 A. These medications are safe. These are all
16 potential side effects.

17 Q. What does that mean, a "potential side
18 effect"?

19 A. Let's take Tylenol for an example. Okay?
20 Tylenol can be very damaging to your liver.

21 Is Tylenol considered a safe medication?
22 Yes, it is.

23 And so like all medications, there are
24 potential side effects. Does that mean we see them
25 happening a lot? No. In fact, the majority of

1 cases, we don't see that at all.

2 I've never seen these things in my patients,
3 nor have they been reported on. In fact, for
4 example, there was a study that looked at heart
5 disease in transgender men who had been taking
6 testosterone.

7 What we tell patients is that their risk for
8 testosterone is higher than if they didn't take
9 testosterone, but it is not higher than cisgender
10 men. It's actually just slightly lower.

11 That's what I mean. All medications have
12 potential side effects.

13 BY MR. RAMER:

14 Q. I'd like to go to Olson-Kennedy Exhibit 4,
15 which is your deposition in Voe versus Mansfield.
16 I'd like to go to page 151.

17 And beginning at line 12 on 151 and carrying
18 over to line 5 on page 152, here you are asked what
19 you mean when you say that gender-affirming medical
20 care as treatment for gender dysphoria, has been
21 shown to be safe.

22 And at page 152, line 3, you say:

23 "I mean that the use of these medications
24 is -- has not been demonstrated to be detrimental to
25 people's physical health."

1 Correct?

2 MR. SELDIN: I'll just object to the
3 testimony on page 151, line 22. The prompt was
4 "gender-affirming medical care as treatment" --
5 (Reporter clarification.)

6 MR. SELDIN: "Gender-affirming medical care
7 as treatment for gender dysphoria, has been shown to
8 be safe and effective and is not experimental or
9 investigational."

10 BY MR. RAMER:

11 Q. And my question for you, Doctor, is: When
12 you were asked what you meant by saying the
13 medications were safe, page 152, line 3, you say:

14 "I mean that the use of these medications
15 is -- has not been demonstrated to be detrimental to
16 people's physical health."

17 Correct?

18 MR. SELDIN: And I'll just object again, the
19 question in this deposition is more than just safe.

20 But you can answer if you understand.

21 THE WITNESS: Yes. I understand, and that's
22 correct.

23 BY MR. RAMER:

24 Q. You began using puberty blockers to treat
25 gender dysphoria back in 2007; correct?

1 A. Correct.

2 Q. And was it around the same time that you
3 first began using cross-sex hormones to treat gender
4 dysphoria in minors?

5 MR. SELDIN: Object to form.

6 THE WITNESS: Do you mean me personally? Or
7 at our clinic?

8 BY MR. RAMER:

9 Q. You personally.

10 A. 2006.

11 Q. And what about at your clinic?

12 A. 1991.

13 Q. And you would agree that when you personally
14 began using puberty blockers and cross-sex hormones
15 to treat gender dysphoria in adolescence, that
16 practice was based on very limited data; correct?

17 MR. SELDIN: Object to form.

18 THE WITNESS: The limited data was in their
19 use among people with gender dysphoria. Yes.

20 BY MR. RAMER:

21 Q. And so when you began using them with
22 adolescents to treat gender dysphoria, that practice
23 was based on very limited data; correct?

24 MR. SELDIN: Object to form.

25 THE WITNESS: In puberty blockers, yes. Not

1 gender-affirming hormones.

2 BY MR. RAMER:

3 Q. For adolescents?

4 A. Correct.

5 Q. You think that there was more than limited
6 data to use cross-sex hormones to treat gender
7 dysphoria in adolescents in 2006?

8 A. I think there was a lot of clinical evidence
9 and experience.

10 Q. When you say "clinical evidence," what are
11 you referring to?

12 A. I mean that in our center, we'd been
13 utilizing gender-affirming hormones for 15 years at
14 that point.

15 MR. RAMER: I'm going to hand what's a very
16 large document to the court reporter to be marked as
17 Olson -- Olson-Kennedy Exhibit -- 10, I believe.

18 (Deposition Exhibit 10 was marked for
19 identification by the court reporter.)

20 MR. RAMER: And for counsel, I did not print
21 out the entire document. I printed out the cover and
22 then the one page that I'm going to be asking about,
23 to save paper.

24 THE WITNESS: Thank you.

25 MR. SELDIN: We appreciate that. As I

1 believe does the witness.

2 BY MR. RAMER:

3 Q. And, Dr. Olson-Kennedy, this is a grant
4 application that you submitted to the National
5 Institutes of Health for our R 01, which is entitled
6 "The Impact of Early Medical Treatment in Transgender
7 Youth."

8 Correct?

9 A. Correct.

10 Q. And you submitted this in 2014; correct?

11 A. Yes.

12 Q. And I'd like to go to the page that is
13 numbered 163 at the bottom.

14 And let me know when you're at that page.

15 A. Yes, I'm there.

16 Q. And that page has a bold and all caps
17 "SPECIFIC AIMS" at the top; correct?

18 A. Correct.

19 Q. And the second paragraph -- I'll just read
20 the full paragraph into the record and ask if I read
21 it correctly.

22 "Current clinical practice guidelines aim to
23 decrease gender dysphoria and ameliorate potential
24 negative health outcomes. Treatment recommendations
25 vary depending on the age and developmental stage of

1 youth with gender dysphoria.

2 "For those youth in the earliest stages of
3 puberty technical development, Tanner 233, treatment
4 with gonadotropin releasing hormone GRH agonists is
5 recommended in order to suppress endogenous puberty
6 and avoid the development of undesired secondary sex
7 characteristics.

8 "In older adolescents in the later stages of
9 pubertal development, Tanner 4 through 5, treatment
10 with cross-sex hormones is recommended to induce
11 desired masculine or feminine features.

12 "While these guidelines have been used at
13 academic and community centers across the U.S., they
14 are based on very limited data.

15 "Furthermore, there are no available data
16 examining the physiologic and metabolic consequences
17 of cross-sex hormone treatment in youth. This
18 represents a critical gap in knowledge that has
19 significant implications for clinical practice across
20 the U.S.

21 "In 2011 a report of the Institute of
22 Medicine called for the development of rigorous
23 research aimed at understanding the health
24 implications of hormone use and other
25 transgender-specific issues."

1 Leaving aside mispronunciations, did I read
2 that correctly?

3 A. Yes.

4 Q. And in the third and fourth sentences of
5 this paragraph, you are discussing using puberty
6 blockers and cross-sex hormones to treat gender
7 dysphoria in adolescents; correct?

8 A. Yes.

9 Q. And the next sentence says:

10 "While these guidelines have been used at
11 academic and community centers across the U.S., they
12 are based on very limited data."

13 Correct?

14 A. Correct.

15 Q. And you personally wrote that sentence;
16 correct?

17 A. I did.

18 Q. And the next sentence says:

19 "Furthermore, there are no available data
20 examining the physiologic and metabolic consequences
21 of cross-sex hormone treatment in youth."

22 Correct?

23 A. Correct.

24 Q. And you personally wrote that sentence;
25 correct?

1 A. I did.

2 Q. So by the time that you told NIH that these
3 interventions were based on very limited data, you
4 had already been providing them for the better part
5 of a decade; correct?

6 MR. SELDIN: Object to form.

7 THE WITNESS: Thirteen years.

8 BY MR. RAMER:

9 Q. What is 13 years?

10 A. We started in 1991 doing clinical care for
11 transgender youth. This was written in 2014.

12 Q. And you first began giving puberty blockers
13 to patients to treat gender dysphoria in 2007;
14 correct?

15 A. Correct.

16 Q. And you first began using cross-sex hormones
17 to treat gender dysphoria in adolescents in 2006;
18 correct?

19 A. Personally, yes.

20 Q. And so then it's seven to eight years later
21 that you are telling NIH that these interventions
22 were based on very limited data; correct?

23 MR. SELDIN: Object to form.

24 THE WITNESS: The were based -- the
25 guidelines were based on little empirical data.

1 Clinical experience is a whole different thing that's
2 considered in the provision of care.

3 BY MR. RAMER:

4 Q. And so by the time that you told -- you told
5 NIH that these interventions were based on very
6 limited empirical data, you had already been
7 providing them for the better part of a decade;
8 correct?

9 MR. SELDIN: Object to form.

10 THE WITNESS: Correct.

11 BY MR. RAMER:

12 Q. Do you think that was ethical?

13 MR. SELDIN: Object to form.

14 THE WITNESS: Yes.

15 BY MR. RAMER:

16 Q. Why?

17 A. I think that clinical experience is a really
18 important part of making care decisions. So what we
19 knew in 2007, the Dutch protocol had come out. And
20 the Dutch had been using puberty blockers for gender
21 dysphoria since, I want to say, 1989, possibly
22 earlier.

23 When they came out with this protocol
24 because the use of puberty blockers had been
25 demonstrated to be safe in even a much younger

1 population, and that they were demonstrated to be
2 helpful in youth with gender dysphoria and we had
3 been using gender-affirming hormones since 1991, it
4 was ethical to offer this as an opportunity for young
5 people.

6 BY MR. RAMER:

7 Q. And that's true even if there's very limited
8 empirical data to support the use of those
9 interventions?

10 MR. SELDIN: Object to the form.

11 THE WITNESS: That is true with all areas of
12 medicine, clinical practice outpaces empirical data.

13 BY MR. RAMER:

14 Q. And so in your view, all you really needed
15 to know whether these interventions were safe and
16 effective, was the Dutch studies; is that right?

17 MR. SELDIN: Object to form. Misstates
18 testimony.

19 THE WITNESS: The Dutch experience.

20 BY MR. RAMER:

21 Q. And so every piece of evidence that we've
22 obtained after 2006 and 2007, is just icing on a cake
23 already frosted; is that right?

24 MR. SELDIN: Object to form. To the
25 wind-up, misstates testimony.

1 THE WITNESS: I think that's a
2 mischaracterization of how all of medicine works.
3 All of medicine starts with clinical practice. And
4 when clinical practice, we have patients that we
5 can -- that are going to consent to studies and
6 enough people to make conclusions, then we add
7 empirical data.

8 This is true across the entire field of
9 medicine. This is absolutely not different at all.
10 BY MR. RAMER:

11 Q. And so how about the very first patients who
12 receive these interventions as part of clinical
13 practice with no empirical data, is that ethical?

14 MR. SELDIN: Object to form. Foundation.

15 THE WITNESS: Are you asking me to make a
16 judgment about the Netherlands?

17 BY MR. RAMER:

18 Q. I'm asking you to make a judgment about your
19 practice.

20 A. Not unethical. We did have empirical data,
21 and they had clinical experience. Not without those
22 things.

23 Q. And the empirical data is exclusively the
24 data coming from the Dutch researchers; is that
25 correct?

1 MR. SELDIN: Object to form. Misstates
2 testimony.

3 THE WITNESS: That's correct.

4 BY MR. RAMER:

5 Q. And that was sufficient for you to feel
6 justified in giving these interventions to patients;
7 correct?

8 MR. SELDIN: Object to form.

9 THE WITNESS: That experience, that
10 empirical data, and what we knew about the use of
11 central blockers in precocious puberty and other
12 indications.

13 For example, endometriosis in adolescence
14 and other things that I talk about in my report where
15 GnRH analogs are utilized for other reasons.

16 BY MR. RAMER:

17 Q. And do you treat precocious puberty?

18 A. I have treated precocious puberty twice
19 because there happened to be overlap with two
20 patients with gender dysphoria.

21 Q. And those patients were also seeing an
22 endocrinologist; correct?

23 A. That is correct.

24 Q. Do you diagnosis precocious puberty?

25 A. Not routinely. But all you need for that

1 diagnosis is that somebody has started puberty before
2 a certain age.

3 Q. And so, in other words, it's just a
4 physical -- it's a diagnosis that's based on physical
5 observation; is that right?

6 MR. SELDIN: Object to form.

7 THE WITNESS: There are also blood tests
8 that go along with that and sometimes bone age
9 studies that go along with that.

10 BY MR. RAMER:

11 Q. And for a patient who is being treated for
12 central precocious puberty exclusively, the treatment
13 for that condition eventually calls for that patient
14 to cease taking puberty blockers and then proceed
15 through endogenous puberty; correct?

16 MR. SELDIN: Object to form. Foundation.

17 THE WITNESS: Correct.

18 BY MR. RAMER:

19 Q. You do not consider yourself an expert in
20 medical ethics; correct?

21 A. That's correct.

22 Q. And looking at your practice generally, you
23 have patients who range in age from four years old to
24 25 years old; correct?

25 A. Yes. Occasionally I will see someone older

1 than that if they have not been able to establish
2 care somewhere.

3 Q. Because it's --

4 Let me back up.

5 Generally your practice is that at age 25,
6 your patients will transition to adult care; correct?

7 A. That's correct.

8 Q. And about 90 to 95 percent of your practice
9 is focused on treating children and adolescents with
10 gender dysphoria; correct?

11 A. That's correct.

12 But I'd like to add context, because it's
13 not always about giving people medical interventions.
14 There are pieces of it that are about
15 psychoeducation. There are pieces of it about
16 consultations. I'm just providing information.

17 For example, I have seen parents with
18 children younger than four, but I don't necessarily
19 see the kid. It really is discussion with parents.

20 Q. And when you say "psychoeducation," what do
21 you mean by that?

22 A. Talking to them about trajectories of
23 development, talking to them or working with them
24 around questions that they have about their child.

25 Q. Do you do psychoeducation with the minor

1 patients as well?

2 A. Yes.

3 Q. And what does that entail?

4 A. Same thing.

5 So people are accessing services at all
6 different points in time relative to their
7 understanding of medical interventions or other
8 interventions that are available. And so that
9 conversation doesn't look the same for everybody, but
10 it's really about providing information. And that's
11 pretty similar across all of adolescent medicine.

12 Q. And what does the other very small
13 percentage of your practice involve?

14 A. Abnormal uterine bleeding, eating disorders,
15 intentional overdose, unintentional overdose, pelvic
16 problems, all things adolescent that adolescents may
17 experience from a medical perspective.

18 Q. And for --

19 Or let me back up.

20 What percentage of patients are in your
21 research protocols?

22 A. Very small percentage.

23 Q. Less than 3 percent? I know you're -- this
24 is an estimate, but I'm just -- just to get a
25 ballpark.

1 A. Maybe 8 percent to 10 percent.

2 I don't know the exact numbers right now but
3 around that.

4 Are you talking about the NIH research or
5 are you talking about all research across the whole
6 Center For Transyouth Health and Development?

7 Q. I was referring to your research protocols.

8 A. Yeah. Probably about 8 to 9 percent, or
9 something like that.

10 Q. And of the patients that you're seeing for
11 gender dysphoria, upwards of 90 percent of those
12 patients are on some form of hormonal intervention;
13 correct?

14 A. So for clarity, everybody that accesses
15 services is not on medical interventions.

16 But people that are being seen over time,
17 right -- because if somebody comes in on one
18 occasion, we have a conversation and they never
19 return, I'm not seeing them frequently, or maybe I'm
20 seeing them less frequently.

21 But for people that I'm seeing on a routine
22 basis, yes, they are undergoing interventions.

23 Q. I guess what -- my question was about the
24 percentage of the patients you're seeing on an
25 ongoing basis for gender dysphoria.

1 A. Mm-hmm.

2 Q. And the question is: What percentage of
3 those patients are on some form of hormonal
4 intervention?

5 A. Probably about 90 percent.

6 Q. And for your transmasculine patients who did
7 not have their puberty suppressed, nearly all of them
8 end up getting chest surgery; correct?

9 MR. SELDIN: Object to form.

10 THE WITNESS: I don't know the exact number,
11 but it's most of them.

12 BY MR. RAMER:

13 Q. In your deposition in Voe versus Mansfield,
14 when you were asked what proportion roughly of your
15 transmasculine patients end up getting chest surgery,
16 you said nearly all of them who were not blocked in
17 early puberty; correct?

18 A. Yes.

19 Q. And as recently as last year, you referred
20 someone under the age of 18 for a genital surgery;
21 correct?

22 A. I have to look at the timing. I'm not sure
23 if it's within the last year. It might have been
24 slightly before that.

25 The timing is -- I don't know.

1 Q. What time frame are you thinking of?

2 A. Well, I've only referred one person, and I
3 can't remember when I referred her, if it was more
4 than a year ago or less than a year ago. It was very
5 close to a year ago.

6 Q. And do you recall specifically what kind of
7 surgery that was?

8 A. It was for vulvovaginoplasty.

9 Q. And can you explain what that is?

10 A. That is the creation of a vulva and a
11 vaginal canal.

12 Q. And what tissue is used to create the vulva
13 and the vaginal canal?

14 A. There are several different procedures. I
15 can't remember which one this patient had, but I can
16 go through them.

17 Q. Just give me a sense of generally what these
18 procedures -- not this particular patient, but these
19 procedures in general, what tissue is used for the
20 procedure?

21 A. So largely dependence on how much puberty
22 that person has experienced. So if somebody has gone
23 all the way through or mostly through endogenous
24 puberty, most frequently a procedure called an
25 inversion procedure is used, and they use the skin of

1 the shaft of the penis.

2 If somebody was blocked earlier, they use
3 different skin. And it's largely dependent upon the
4 patient. Sometimes they use the lining of the
5 peritoneal cavity. And sometimes they use skin of
6 the scrotum. And sometimes they use skin from the
7 outside lower groin.

8 And probably other things. I'm not a
9 surgeon, but...

10 Q. That's fair.

11 And in your practice, you think there can be
12 times where it's appropriate to prescribe cross-sex
13 hormones at the patient's first visit to your clinic;
14 correct?

15 MR. SELDIN: Object to form.

16 THE WITNESS: It can be. But that would
17 be -- based on them either having had a complete
18 workup already, including their assessment and their
19 preliminary labs, that would be the only time that I
20 would find that appropriate.

21 BY MR. RAMER:

22 Q. And it's possible that you have personally
23 prescribed cross-sex hormones on a patient's second
24 visit; correct?

25 A. Correct.

1 Q. And similarly, it's possible that you have
2 personally prescribed puberty blockers for a patient
3 as early as the second visit; correct?

4 A. It's possible. Again, similar to what I
5 talked about previously.

6 Q. And there might be situations where someone
7 will be prescribed puberty blockers during their
8 first visit to your clinic; correct?

9 MR. SELDIN: Object to form.

10 THE WITNESS: Similar to what I said before,
11 they would've had to have had the majority of their
12 workup done in another place or for a variety of
13 reasons.

14 BY MR. RAMER:

15 Q. And we were discussing this a little bit
16 before, but you --

17 Let me back up.

18 The general practice in your clinic is to
19 follow patients until they are 25 years old and then
20 transition to adult care; correct?

21 A. Correct.

22 Q. And at that point, unless those patients are
23 in your research protocols, you do not follow
24 patients from age 25 onward; correct?

25 A. Correct.

1 Q. And so you do not have clinical experience
2 related to your patient outcomes after 25 years of
3 age; correct?

4 MR. SELDIN: Object to form.

5 THE WITNESS: That's correct.

6 BY MR. RAMER:

7 Q. When you prescribe a patient puberty
8 blockers, you do not expect an increase in body
9 satisfaction; correct?

10 A. It's not the same for every patient. Some
11 people have improvement and some people don't.

12 If you look at the overarching response, at
13 least what our data is demonstrating, it's pretty
14 much neutral.

15 That doesn't capture the variability in each
16 individual.

17 Q. And so when you say that puberty blockers
18 are effective, all you mean by that is that they halt
19 endogenous puberty; correct?

20 MR. SELDIN: Object to form. Misstates
21 testimony.

22 THE WITNESS: Well, like I said, it's an
23 individual thing. So there are some people that
24 experience a lot of distress about going through
25 puberty or the idea of going through puberty. And

1 for those patients, their anxiety and stress
2 diminishes because they don't have to think about
3 that anymore.

4 There are some people who go on puberty
5 blockers who experience a lot of anxiety about the
6 fact that they are not going through the puberty that
7 aligns with their gender. So for them, they might
8 have increased anxiety.

9 That's why I'm saying there's variability
10 between individuals.

11 BY MR. RAMER:

12 Q. But the purpose of prescribing the puberty
13 blockers as part of the sequence of gender-affirming
14 care, is not to decrease anxiety and distress;
15 correct?

16 MR. SELDIN: Object to form.

17 THE WITNESS: Correct. It's to stop the
18 progress of their endogenous puberty.

19 BY MR. RAMER:

20 Q. And there is no instrument for measuring
21 gender dysphoria; correct?

22 MR. SELDIN: Object to form.

23 THE WITNESS: There are a handful of scales
24 that attempt to do that and, for example -- but I
25 think the earliest ones that we see, the Utrecht

gender dysphoria scale does not.

I think that there are other scales that I've talked about before -- I can't remember the exact name. I will in a minute -- that have been proposed and have been modified over time.

BY MR. RAMER:

Q. But you do not in your practice or research, use an instrument that specifically measures gender dysphoria; correct?

A. We use a combination of instruments for that.

Q. What combination?

A. Well, we have not put this together formally yet, but we utilize -- transgender congruence is one of the most common scales that actually measures both acceptance and appearance, which helps us understand about the gap between someone's physicality and their gender, which is the purpose of utilizing gender-affirming hormones.

Does that capture all of gender dysphoria? No. But it does capture this idea of minimizing this gap to the best of our ability.

Q. And there is no instrument that you're aware of that would fully minimize that gap; correct?

A. Well, the instrument that captures the gap

and the gap closing, is the transgender congruence scale, appearance subscale. And that's why -- (Reporter clarification.)

THE WITNESS: The transgender congruence scale, specifically the appearance congruence subscale.

BY MR. RAMER:

Q. And when you were discussing the transgender congruence scale, you measure -- excuse me -- you mentioned both acceptance and appearance; correct?

A. Correct.

Q. And can you explain what you mean by "acceptance"?

A. So the transgender congruence scale has these two subscales. So the acceptance piece is about --

I didn't know if you needed a minute.

Q. No. I'm sorry.

A. -- the pieces about self-acceptance.

Q. Self-acceptance of what?

A. Transexperience, transgender experience.

Q. And what is appearance measuring?

A. Appearance congruence? It's measuring how aligned somebody's physicality is with their gender.

Q. And I think we've discussed this, but I want

to make sure, that for any particular patient, the gender-affirming medical intervention that is indicated, is driven by the patient's embodiment goals; correct?

A. That's correct.

Q. And you think that gender-affirming care includes a natal female receiving implants to have larger breasts; correct?

MR. SELDIN: Object to form.

THE WITNESS: I think you might have said that backwards.

Somebody who is designated female at birth doesn't -- probably doesn't want or need implants.

BY MR. RAMER:

Q. During your deposition in Noe versus Parson, you were asked if a natal female identifies as female, but naturally has a very small chest and wants a breast augmentation to better align her body with her conception of her gender as female, would that also be gender-affirming in your terminology, and you answered "yes"; correct?

A. Yes.

Q. And so you think gender-affirming care includes a natal female receiving implants to have larger breasts; correct?

MR. SELDIN: Object to form.

THE WITNESS: Correct.

MR. RAMER: And I'm at a decent stopping point.

THE WITNESS: Thank you.

MR. RAMER: Let's go off the record.

THE VIDEOGRAPHER: The time is 11:51 a.m.

We are off the record.

(Lunch recess.)

MR. SELDIN: Ready to go.

THE VIDEOGRAPHER: One moment, please.

The time is 12:34 p.m.

We are back on the record.

BY MR. RAMER:

Q. Dr. Olson-Kennedy, welcome back.

A. Thank you.

Q. I'd like to return to Olson-Kennedy Exhibit 6, which is your amicus brief.

And I'd like to go to page 20.

And under the bold No. 1, there's a

paragraph where the brief is talking about using the

GRADE, all caps, "METHODOLOGY FOR ASSESSING EVIDENCE QUALITY."

Correct?

A. Yes.

1 Q. And you have never used the GRADE
2 methodology; correct?

3 A. That's correct.

4 Q. And you do not know how the GRADE
5 methodology considers expert opinion versus other
6 types of evidence; correct?

7 A. I have heard people assert that over the
8 last handful of months.

9 Q. Apart from those assertions, you do not have
10 an understanding of how the GRADE methodology
11 distinguishes between expert opinion and other types
12 of evidence; correct?

13 A. That's correct.

14 Q. And sticking with this brief, like to go to
15 page 4.

16 And first full paragraph on the page,
17 there's a sentence that begins with "First." Then
18 there's a citation, and then there's a sentence that
19 begins with "These reviews."

20 Do you see that?

21 A. Yes.

22 Q. And I'll first just ask -- I'll first read
23 it and ask if I read it correctly.

24 It says:

25 "These reviews are billed as systematic

1 reviews, a rigorous type of literature search
2 considered to be the gold standard for assessing the
3 quality of medical evidence, and were conducted by
4 authors affiliated with the University of York,"
5 parenthesis, "the York SRs."

6 Did I read that correctly?

7 A. Yes.

8 Q. And do you agree that systematic reviews are
9 the gold standard for assessing medical?

10 A. I guess.

11 Q. What do you mean you guess?

12 A. I -- I mean, I'm not -- this is not my field
13 of study. This is what is said in the general world.

14 But my concern is that systematic reviews
15 are very biased.

16 Q. Biased in --

17 A. Essentially very biased.

18 Q. Biased in what way?

19 A. So I think as we talk about in -- in this
20 report that we published, the criterion for
21 consideration in the review is subjective, so people
22 pick it. Right? That's a human being on the other
23 end of it that's picking the criteria.

24 So is it leaving out a lot of studies?

25 Yeah, like as witnessed by the York systematic

1 reviews. They left out a lot of studies. And they
2 left them out for reasons like, they -- they
3 considered under 18 and 18 and older, so they were
4 disqualified. Right?

5 Or they didn't measure this specific outcome
6 that we identified as important. Right? That's --
7 that's a significant issue with systematic reviews.

8 Q. And is that an issue with systematic reviews
9 generally or specifically with the systematic reviews
10 associated with the Cass Review?

11 A. Generally they all are subjective in that
12 way.

13 Q. And so do you consult systematic reviews as
14 part of your practice?

15 A. Possibly in the past. Not that I can recall
16 specifically.

17 Q. And you've never conducted a systematic
18 review; correct?

19 A. That's correct.

20 Q. In your opinion, should a systematic review
21 look at the safety of the interventions under study?

22 MR. SELDIN: Object to form.

23 THE WITNESS: I think that depends on what
24 the systematic review is doing.

25 ///

1 BY MR. RAMER:

2 Q. Can you explain what you mean by that?

3 A. So if a systematic review is undertaking --
4 again, broadly conceptualizing what the purpose of
5 the systematic review is, is a really important part
6 of that question.

7 So if the systematic review overall is
8 saying, we want to look at all of the evidence, well,
9 what if it's not an intervention that's related to
10 safety? Right?

11 What if it's an intervention that is
12 completely unrelated? Then that wouldn't be an
13 important thing, necessarily.

14 But if they're looking at the -- they're
15 looking at the results of intervention specifically
16 related to medications or surgical things, then
17 safety is an important part of it.

18 Q. How many systematic reviews have you read
19 that assess the quality of the evidence for using
20 medical interventions to treat gender dysphoria in
21 minors?

22 A. Probably five or six. I don't know the
23 exact number.

24 Q. And do you recall which ones you read?

25 A. I have read the York systematic reviews,

1 which I think -- well, I don't know if we call the
2 one that -- this is an exact example. Right? It's
3 analyzing standards of care. Right? I don't think
4 they were analyzing for the safety of the standards
5 of care development. That one.

6 There were two about blockers. There was
7 one about social transition. There was the one that
8 was from the Johns Hopkins group for the standards of
9 care development.

10 There's another one. I can't remember the
11 author. I'd have to look back, 'cause I think it
12 he's in my bibliography.

13 So, yeah, six or -- six or seven, something
14 like that.

15 Q. And do you recall generally what the
16 conclusions were of the systematic reviews that you
17 have read that assess the quality of evidence for
18 using medical interventions to treat gender dysphoria
19 in minors?

20 A. Well, it depends on the review. So I think,
21 like, this is another thing that was -- was
22 unexplained in the Cass report, that both of the
23 Taylor reviews, they actually found a moderate and
24 high quality evidence for the interventions. But
25 that wasn't really talked about very much in the

1 Cass Review.

2 Other reviews have also come to the
3 conclusion that there needs to be more data. And it
4 depends on the specific thing that they're looking
5 at.

6 Q. And are you able to name a single study
7 demonstrating that any form of medical transition
8 reduces the rate of completed suicide among any
9 population of minors?

10 MR. SELDIN: Object to form. Foundation.

11 THE WITNESS: I really don't know how a
12 study would look at rate of completed suicides and
13 their reasons. I just don't think that's possible.

14 BY MR. RAMER:

15 Q. And so you would say it's pointless to even
16 try to review literature on the connection between a
17 form of medical transition and death by suicide;
18 correct?

19 MR. SELDIN: Object to form. Misstates
20 testimony.

21 THE WITNESS: I am open to somebody
22 proposing how such a study would be done. But I have
23 never seen that, nor can I conceptualize how that
24 would be done.

25 ///

1 BY MR. RAMER:

2 Q. And during your deposition in
3 Noe versus Parson, you were asked whether you were
4 saying that it would be pointless to even try to
5 review literature on the connection between a form of
6 medical transition and death by suicide.

7 And your answer was "Correct, yes."
8 Correct?

9 A. Yes.

10 Q. And sticking with Exhibit 6, which is your
11 amicus brief, going to page 18.

12 And in the first paragraph -- excuse me --
13 in the first paragraph, about halfway down, you're
14 criticizing the Cass Review's use of the Newcastle
15 Ottawa scale; correct?

16 A. Correct.

17 Q. And you have never used the Newcastle Ottawa
18 scale; correct?

19 A. That's correct.

20 Q. And going to page 24, the same exhibit, the
21 first full sentence on this page says:

22 "Indeed the GRADE authors state explicitly
23 that technically low quality evidence can and does
24 support strong recommendations for clinical care."

25 Did I read that correctly?

1 A. Yes.

2 Q. You are not familiar with the paradigmatic
3 examples in which the GRADE system says one can make
4 a strong recommendation based on low quality
5 evidence; correct?

6 MR. SELDIN: Object to form.

7 THE WITNESS: I'm not sure I know what that
8 means.

9 BY MR. RAMER:

10 Q. And in your deposition in Noe versus Parson,
11 you were asked:

12 "Are you familiar with the developers of the
13 GRADE system providing the paradigm under which you
14 can make a strong recommendation based on low quality
15 evidence?"

16 And your answer was "no"; correct?

17 A. Correct.

18 THE REPORTER: 11.

19 (Deposition Exhibit 11 was marked for
20 identification by the court reporter.)

21 BY MR. RAMER:

22 Q. And, Dr. Olson-Kennedy, you've been handed
23 what's been marked Olson-Kennedy Exhibit 11; correct?

24 A. Correct.

25 Q. And is this one of the Taylor systematic

1 reviews you were referencing earlier?

2 A. Yes.

3 Q. And on the first page under the aim, you can
4 see that this was a systematic review conducted to
5 examine the quality and development of published
6 guidelines or clinical guidance containing
7 recommendations for managing gender
8 dysphoria/incongruence in children and/or adolescence
9 age zero to 18.

10 Correct?

11 A. Yes.

12 Q. And if you go to the second page of this
13 document, and the right column, under the blue
14 quality appraisal, there's a sentence, and then
15 there's a sentence that begins with "We used."

16 Do you see that?

17 A. I do.

18 Q. It says:

19 "We used the Appraisal of Guidelines for
20 REsearch & Evaluation (AGREE) II instrument to assess
21 quality"; correct?

22 A. Correct.

23 Q. And you're not familiar with the AGREE II
24 scale; correct?

25 A. I am not.

1 Q. And sticking with this exhibit, I'd like to
2 go to page 5 and specifically Table 1.

3 And do you see there is a column entitled
4 "Rigor of Development"?

5 A. Yes.

6 Q. And in that column, the highest scoring
7 guidelines for rigor of development are the
8 guidelines from the Swedish National Board of
9 Health & Welfare, 2022; correct?

10 A. Yes.

11 Q. You are not familiar with those guidelines,
12 are you?

13 A. I am not.

14 Q. And returning to Exhibit 6, which is your
15 amicus brief.

16 I'd like to go to page 21.

17 And second full paragraph, first two
18 sentences, I'll read them and ask if I read them
19 correctly.

20 It says:

21 "There are also ethical barriers to RCTs.
22 If participation in a research study is the only way
23 to access medically affirming interventions that have
24 substantial evidence demonstrating their
25 effectiveness, the result is coercion, which is

1 condemned by medical and scientific ethical rules."

2 Did I read that correctly?

3 A. Yes.

4 Q. And this is a point that is made in your
5 paper that's referenced in footnote 3 of this brief;
6 correct?

7 A. I'm sorry. You're going to have to walk me
8 back again. Which paper? This one?

9 Q. The paper that this brief is adapted from.

10 A. Oh, oh, oh. Okay.

11 Q. And my question is just this point that I
12 just read, that's something that's also made in your
13 paper; correct?

14 A. Yes.

15 Q. And that's a part of the paper that you
16 wrote; correct?

17 A. Correct.

18 Q. And would you agree that the point you make
19 in this paragraph assumes that medically affirming
20 interventions have substantial evidence demonstrating
21 their effectiveness?

22 MR. SELDIN: Object to form.

23 THE WITNESS: Yes.

24 BY MR. RAMER:

25 Q. And so if the purpose of the RCT is to

1 determine whether there is evidence of effectiveness,
2 there would not be an ethical barrier; correct?

3 MR. SELDIN: Object to form.

4 THE WITNESS: The ethical barrier is what's
5 recommended in --

6 The ethical barrier is twofold. The first
7 one is, you can't randomize someone to no treatment
8 when there is existing treatment. That has been
9 demonstrated both empirically and clinically to be
10 effective. That's the first piece.

11 The second piece that -- what you see here,
12 is talking about only making access available to
13 someone who participates in research because that's
14 coercion.

15 BY MR. RAMER:

16 Q. And it's only coercion, though, if the
17 intervention at issue has substantial evidence of
18 effectiveness; correct?

19 A. No. I don't think you can ever say to
20 someone, you can only access this if you're in a
21 research protocol. That's not how medicine works.

22 Going back to what I said before, is that
23 clinical care far outpaces empirical evidence. It --
24 there's more of an abundance of it. And it also has
25 to be a predecessor to scientific investigation.

1 So I don't really know how you would say to
2 someone, you can only have this access if you're in a
3 research trial.

4 Maybe in the case of cancer or something
5 like that, but I'm not familiar with that domain of
6 medicine.

7 But as far as I know, requiring people to be
8 in research is coercion.

9 Q. And that point applies not just to
10 gender-affirming medical interventions, but to all
11 medical interventions; correct?

12 A. I can't speak for every single medical
13 intervention. But in general, not allowing people
14 access to care except through a research protocol is
15 a problem.

16 Q. And I just -- to make sure we're not
17 quibbling over the word "care," when you use the word
18 "care," are you -- does the word "care" in your view
19 carry with it some sort of sense of established
20 evidence showing effectiveness?

21 A. As opposed to?

22 Q. A medical intervention where we don't know
23 whether it's effective or not.

24 A. I don't know. I haven't lived in the world.
25 I think the only place where that happens is like

1 experimental drugs and cancer treatment, where they
2 have, like, okay, we can try this, but we're not
3 guaranteeing it's going to work, or something like
4 that.

5 But that's not my field of expertise.

6 Q. Well, in the context of an experimental drug
7 where they're saying, we can try this, and it might
8 work, but it might not, do you think that limiting
9 the use of that experimental drug to research trials
10 is coercive?

11 MR. SELDIN: Object to form.

12 THE WITNESS: I don't know. I'd have to
13 think about that for a longer period of time.

14 BY MR. RAMER:

15 Q. What would you need to think about?

16 A. I'd have to think about a scenario in which
17 that happened, which I don't know of any. And so
18 that makes it hard for me to form an opinion about.

19 Q. And so if it were the case that
20 gender-affirming medical interventions did not have
21 substantial evidence demonstrating their
22 effectiveness, you could not say that limiting the
23 use of those interventions to a research trial is
24 coercive; correct?

25 MR. SELDIN: Object to form.

1 THE WITNESS: That was a long sentence.

2 I -- so, for example, I have no idea if
3 when, for example, the Dutch started using blockers
4 for youth with gender dysphoria, if everyone was
5 enrolled in a study.

6 My guess is probably what happened was that
7 they collected data routinely and then went back and
8 looked at it. In other words --

9 I don't know this for sure, but a lot of
10 times what happens is people are collecting data in
11 the course of their clinical care, and then they go
12 back and analyze it. And they don't say, we're
13 prospectively enrolling people and we're going to
14 watch what happens to them.

15 It's, we're -- we're doing this clinical
16 care, and we utilize these tools at different time
17 points.

18 I don't know if that's what they did or not.

19 I think that, again, the situation in these
20 countries that have a national health system, are
21 very different than the ones in the United States.

22 BY MR. RAMER:

23 Q. And so you think it's possible that the
24 Dutch researchers began --

25 Let me back up.

1 You think it's possible that the Dutch
2 clinicians began prescribing puberty blockers as a
3 treatment for gender dysphoria before they began
4 studying it as part of a research trial?

5 Is that correct?

6 MR. SELDIN: Object to form.

7 THE WITNESS: I know that the first thing
8 that the Dutch ever published was a case review, and
9 that's not a prospective trial. That's the situation
10 of one individual.

11 So I can't answer whether they did or not,
12 but I do know that their first publication about this
13 was not a prospective longitudinal trial.

14 BY MR. RAMER:

15 Q. Do you think it would be unethical to
16 conduct a research trial with two arms, where one
17 arm --

18 Let me back up.

19 In the context of adolescents with gender
20 dysphoria, do you think it would be ethical to
21 perform a research trial where there are two arms to
22 the trial. One arm is referring to psychotherapy;
23 one arm is receiving psychotherapy and medical
24 interventions?

25 A. Well, there have been studies like that that

1 have looked at exactly those comparisons.

2 But are you talking about like you never
3 giving me medical intervention and -- or over time,
4 you're going to get medical intervention?

5 I don't think it's ethical to say, you're
6 not going to get any medical intervention ever. And
7 it's not only unethical, it's not feasible.

8 Q. What's not feasible?

9 A. To enroll people into a mental health only
10 arm.

11 Q. Why is that not feasible?

12 A. Because they wouldn't want to do it.

13 Q. And when you say there have been studies
14 conducting that type of research, are you referring
15 to anything other than the Costa study?

16 A. I think that -- I have to look through the
17 study specifically. But I think Van Der Miesen did
18 this also.

19 Q. And -- so you say it would -- just to back
20 up and answer -- the question is: That type of
21 question is ethical; correct?

22 A. The one -- the Costa study? C-o-s-t-a?

23 Q. If the Costa study is a study like the one
24 that I described of two arms, one arm receiving
25 psychotherapy, another receiving psychotherapy and

1 medical interventions, that study is ethical;
2 correct?

3 MR. SELDIN: Object to form.

4 THE WITNESS: I don't remember if the
5 follow-up with the psychotherapy-only arm was
6 intended to get treated. I don't remember that. I
7 have to go back to the paper.

8 If it was never intended to get care, I
9 would not think that was ethical actually.

10 BY MR. RAMER:

11 Q. What if the study was designed that they
12 would receive care when they turn 18?

13 A. Maybe.

14 Q. Maybe what?

15 A. Maybe that could be ethical. I'd have to
16 see it to -- to make that determination.

17 Q. Because what gives you concern about that
18 type of study?

19 A. I think a type of study that does not allow
20 people access to care when they first engage in care,
21 is really problematic for people. We know that
22 untreated gender dysphoria is really harmful.

23 And so what we're talking about is over, you
24 know, a hundred years or more, psychotherapy is the
25 sole intervention, as monotherapy is not effective.

1 There have never been studies demonstrating
2 that. It is not effective in eradicating or
3 significantly decreasing gender dysphoria.

4 So now you're talking about randomizing an
5 arm of the study into something that we know is
6 harmful, which is gender dysphoria, with a treatment
7 that has never been proven to be successful.

8 Q. So to break that down, for one, you could
9 conduct a study, like the one I'm describing, without
10 randomizing patients; correct?

11 A. Yes, you could.

12 Q. And did I understand in your answer -- did
13 you say something that there have been studies for a
14 century saying that psychotherapy doesn't work for
15 gender dysphoria?

16 A. There have been -- the predominant issue,
17 when gender dysphoria, transgender experience moved
18 into the world of medicine and science, people
19 thought that psychotherapy was what would make people
20 not be trans anymore. And that's never been
21 demonstrated to be true.

22 It did not talk about gender dysphoria in
23 the way that we're talking about it today.

24 But because being gender incongruent was
25 considered psychopathological, the efforts were aimed

1 at therapy, psychiatry, mental health therapy,
2 sexology. All of those things.

3 And over that time, there has never been a
4 study demonstrating that psychotherapy alone manages
5 gender dysphoria.

6 Q. Do you agree that there's a distinction
7 between psychotherapy with the purpose of making
8 someone not transgender and psychotherapy with the
9 purpose of resolving somebody's distress associated
10 with gender dysphoria?

11 A. Yes, there's a difference between those
12 things.

13 Q. And I'm talking about the latter category,
14 the psychotherapy that is done for the purpose of
15 resolving distress associated with gender dysphoria.

16 And my question is: Do you think that
17 qualifies as care for gender dysphoria?

18 A. Not by itself. I think that psychotherapy
19 can help people manage their distress. But I don't
20 think it is eliminating the consternation that they
21 feel about the misalignment.

22 Q. What's the basis for that opinion that you
23 just gave?

24 A. A hundred years of people trying to do that.
25 And when medications became available, people used

1 them to close that gap. And have been for 90 years,
2 80, 90 years.

3 Q. And so, just to make sure I understand.
4 Your opinion is that psychotherapy to help resolve
5 distress associated with gender dysphoria is
6 ineffective based on studies from the last 80 to
7 90 years; is that right?

8 MR. SELDIN: Object to form.

9 THE WITNESS: The lack of studies that
10 demonstrate that.

11 And there's not -- in the world of clinical
12 care, even people that this was their whole life's
13 work actually have not --

14 They -- maybe there's one example or two
15 examples, but there is not even scant evidence of
16 that.

17 BY MR. RAMER:

18 Q. Scant evidence of what?

19 A. Of psychotherapy resolving gender dysphoria.

20 Q. Then why do we do it?

21 A. Because it's partnered with medical
22 interventions. Because you can help move that gap to
23 a closer place and help people manage their anxiety
24 related to it.

25 Those things can go hand-in-hand, and they

1 do, especially with youth care. They go
2 hand-in-hand. The -- it's -- it is not -- it's
3 not -- it's never been shown that psychotherapy alone
4 manages gender dysphoria.

5 Q. And your opinion is that it has been
6 demonstrated that it does not; is that right?

7 A. Yes. That's correct.

8 Q. And is it your opinion that the --

9 Just backing up.

10 If -- is it your opinion that medical
11 interventions are necessary in every patient to treat
12 gender dysphoria?

13 MR. SELDIN: Object to form.

14 THE WITNESS: I -- I can't possibly answer
15 that because I haven't met everybody with gender
16 dysphoria.

17 The people in my practice, they needed
18 medical interventions.

19 BY MR. RAMER:

20 Q. All of them?

21 A. The people with gender dysphoria, yeah.

22 Q. And I'd like to return to your declaration,
23 which is Olson-Kennedy Exhibit 1.

24 And I'd like to go to page 9 and paragraph
25 34.

1 And there you say:

2 "Under the WPATH SOC and other well-accepted
3 clinical practice guidelines for the treatment of
4 gender dysphoria, care should be provided using an
5 individualized approach."

6 Did I read that correctly?

7 A. Yes.

8 Q. And can you explain what it means to use an
9 individualized approach to providing care?

10 A. That the needs of each person are not
11 identical to the needs of each -- of other people;
12 that the recommendations that we make have to be
13 specific for the individual that's in front of us.

14 Q. And so basically no two patients are the
15 same; is that right?

16 A. That's correct.

17 Q. And every patient has to be evaluated as an
18 individual based on the patient's history,
19 comorbidities and relationships, among many other
20 variables; correct?

21 MR. SELDIN: Object to form.

22 THE WITNESS: Correct.

23 THE REPORTER: Exhibit 12.

24 (Deposition Exhibit 12 was marked for
25 identification by the court reporter.)

1 BY MR. RAMER:

2 Q. And, Dr. Olson-Kennedy, you've been handed
3 what's been marked as Olson-Kennedy Exhibit 12;
4 correct?

5 A. That's correct.

6 MR. SELDIN: And, Mr. Ramer, I'm just going
7 to interrupt for a moment.

8 This appears to be something not included on
9 the list you recently disclosed. I would just ask
10 that we have a couple minutes to review it.

11 MR. RAMER: I'm fine with allowing you to
12 review it. This was used as an exhibit during
13 Dr. Olson-Kennedy's Noe v Parson deposition, which is
14 included in the documents we identified.

15 But happy to go off the record and allow a
16 chance to review it.

17 MR. SELDIN: No, I appreciate that
18 clarification. Thank you.

19 A minute would be fine, then.

20 MR. RAMER: Go off.

21 THE VIDEOGRAPHER: The time is 1:05 p.m.

22 We are off the record.

23 (Off record.)

24 MR. SELDIN: We're fine now.

25 THE VIDEOGRAPHER: One moment, please.

1 The time is 1:06 p.m.
 2 We are back on the record.
 3 BY MR. RAMER:
 4 Q. Dr. Olson-Kennedy, the document marked as
 5 Olson-Kennedy Exhibit 12 is a New York Times article
 6 entitled "Biden Administration Opposes Surgery for
 7 Transgender Minors"; correct?
 8 A. Yes.
 9 Q. And you've seen this article before;
 10 correct?
 11 A. I have.
 12 Q. And the first sentence below the you had
 13 been granted access, starts with "the Biden
 14 Administration."
 15 Do you see that?
 16 A. I do.
 17 Q. And I'm going to read that sentence first
 18 and ask whether I read it correctly.
 19 It says:
 20 "The Biden Administration said this week
 21 that it opposed gender-affirming surgery for minors,
 22 the most explicit statement to date on the subject
 23 from a president who has been a staunch supporter of
 24 transgender rights."
 25 Did I read that correctly?

1 we're colleagues, but...
 2 Q. Do you think he's a reliable source of
 3 information?
 4 A. I do.
 5 Q. And have you spoken with him before?
 6 A. Yes.
 7 Q. Are you familiar with Dr. Helen Webberley?
 8 A. Yes.
 9 Q. Who is she?
 10 A. Helen Webberley was a -- is. I shouldn't
 11 say "was." She's still alive.
 12 She is a doctor in the U.K., who was
 13 practicing gender-affirming care outside of the NHS.
 14 Q. And have you spoken with her before?
 15 A. Mm-hmm.
 16 Q. And --
 17 A. Yes.
 18 Q. Sorry.
 19 Go ahead.
 20 A. Yes, I have.
 21 Q. And do you think that she's a reliable
 22 source of information?
 23 A. I don't really know Helen that well. I
 24 think that my understanding generally of her, is that
 25 she is a fine person. I really can't comment further

1 A. You did.
 2 Q. And it's your understanding that this
 3 statement had come from a staffer; correct?
 4 A. I had heard that. I have no idea who the
 5 statement came from, except from these authors at the
 6 New York Times.
 7 Q. And where did you hear that it came from a
 8 staffer?
 9 A. I don't remember.
 10 I was trying to figure out where I could
 11 even see this, and I couldn't find it. And I saw a
 12 lot of speculation online, so I have no idea.
 13 And the speculation was that it came from a
 14 staffer. I don't really actually know what it means
 15 when something comes from an administration. I think
 16 that's a very vague comment.
 17 Q. That's a fair point.
 18 And so the assertion that it came from a
 19 staffer, you were saying was something that you saw
 20 online; is that right?
 21 A. Yes.
 22 Q. Are you familiar with Dr. Jack Turban?
 23 A. I -- I know Jack.
 24 Q. Do you know him well?
 25 A. I don't know about well. I mean, we're --

1 than that.
 2 Q. Do you respect her as a medical
 3 professional?
 4 A. Yes.
 5 THE REPORTER: Exhibit 13.
 6 (Deposition Exhibit 13 was marked for
 7 identification by the court reporter.)
 8 THE WITNESS: Thank you.
 9 BY MR. RAMER:
 10 Q. And, Dr. Olson-Kennedy, you've been handed
 11 what's been marked as Olson-Kennedy Exhibit 13, which
 12 you can see at the top is from genderGP.com.
 13 Do you see that?
 14 A. I do.
 15 Q. Have you seen this document before?
 16 A. I have not.
 17 Q. I'll represent to you that it's a transcript
 18 from a podcast that Dr. Turban did with Dr. Webberley
 19 and another individual.
 20 And my questions relate to page 11 of this
 21 document.
 22 MR. SELDIN: And, Mr. Ramer, has this been
 23 previously marked at a deposition?
 24 MR. RAMER: It had -- not to my knowledge.
 25 MR. SELDIN: Okay.

1 BY MR. RAMER:

2 Q. And on page 11, toward the bottom of the
3 page, you see there's a paragraph that begins
4 "Dr. Helen Webberley."

5 Do you see that?

6 A. Yes.

7 Q. And the second sentence starts with "I'd
8 love to talk to you."

9 Do you see that?

10 A. Yes.

11 Q. And it says:

12 "I'd love to talk to you all day, but we
13 haven't got all day, but Marianne and Abby and I
14 went over to Los Angeles to listen to Johanna
15 Olson-Kennedy, and Aiden and Darlene Tando to talk."

16 Did I read that correctly?

17 A. Yes.

18 Q. And who is Aiden?

19 A. I'm assuming that she's talking about my
20 husband.

21 Q. And who is Darlene Tando?

22 A. She is a therapist in San Diego that works
23 with transgender young people and their families.

24 Q. And what event is it that Dr. Helen
25 Webberley would have attended where you, Aiden and

1 Darlene Tando were speaking?

2 A. Well, we speak together frequently. We do
3 trainings together.

4 Q. Do you recall Dr. Helen Webberley attending
5 one of your trainings?

6 A. Not really.

7 Q. And continuing with this paragraph, it says:

8 "In jest, I've said it before, I say it
9 again. So inspirational, you know, absolutely.

10 "And so you said a couple of things, but if
11 I was wanting to, if I was rewriting the rule book
12 for transgender care, I think, you know, they've
13 coined it, and you've added to it today.

14 "And basically Johanna has just said, look,
15 if your kid -- if your kid tells you that they're
16 trans, they most likely are. Just believe it."

17 Did I read that correctly?

18 A. You did.

19 Q. Is that something you said?

20 A. It could've been something I said. I don't
21 remember this time specifically, but yes.

22 Q. That's something you believe, though?

23 A. Yes.

24 Q. And next paragraph below that, there's an
25 answer from Dr. Jack Turban. And I'll just read the

1 first two sentences of that. It says:

2 "Yeah, I was really talking around it and
3 not naming names, but that model does exist in the
4 U.S., right? So Dr. Olson, that's her model."

5 Did I read that correctly?

6 A. You did.

7 Q. In an Informed Consent model of care, so
8 long as the patient provides Informed Consent for an
9 intervention, the provider will provide that
10 intervention; correct?

11 MR. SELDIN: Object to form.

12 THE WITNESS: Yes.

13 BY MR. RAMER:

14 Q. And in a gatekeeping model, there may be
15 times where a patient can provide Informed Consent,
16 but the provider will determine that the patient is
17 not a good candidate for a particular intervention;
18 correct?

19 MR. SELDIN: Object to form.

20 THE WITNESS: I actually think that can
21 happen in an Informed Consent model, too.

22 BY MR. RAMER:

23 Q. Can you explain how that's possible?

24 A. Well, I -- I think that there's this binary
25 of -- there's these two models, Informed Consent and

1 gatekeeping.

2 But I don't think that's true because I
3 don't follow either of those models.

4 I think that there is a model where an
5 assessment happens, and recommendations are made
6 based on that assessment.

7 So I think that -- I think of a gatekeeper
8 model more as like the mental health provider that
9 you're working with can keep somebody from getting
10 care.

11 That feels really different to me than, oh,
12 you're assessing somebody, and then you're making a
13 recommendation based on what you've gleaned from that
14 assessment.

15 Assessment, assessments, that's, in my -- in
16 my model, that's what we utilize.

17 Q. What's a situation where a patient could
18 provide Informed Consent or informed ascent, but you
19 would deny the intervention based on the assessment?

20 MR. SELDIN: Object to form.

21 THE WITNESS: I think this goes back to what
22 I was saying before, that if somebody thinks, for
23 example, like, oh, I'm going to take medication and
24 it's going to change "X," and -- and I say, well, no,
25 it's not actually. This is not a good idea for you.

1 Then that would be an example.

2 BY MR. RAMER:

3 Q. But a person who misunderstands what the
4 intervention actually does is not capable of
5 providing Informed Consent; right?

6 A. Well, I think it's important here to
7 remember that Informed Consent models are really
8 about adult care. There aren't adolescent
9 Informed Consent models, 'cause they can't legally
10 provide Informed Consent related to gender care.

11 Their parent or guardian has to do that.
12 They also sign the consent form, but that's not
13 legal.

14 Q. When you say "that's not legal," you mean
15 that doesn't establish legal consent. Is that what
16 you're saying?

17 A. Correct.

18 Q. And is there ever a situation where a minor
19 could provide informed ascent, the parent or
20 caretaker could provide Informed Consent, but you
21 would deny the intervention based on an assessment?

22 A. Yes.

23 Q. And what examples can you give me?

24 A. It's rare. Let me try to see if I can think
25 of some examples.

1 deny the intervention?

2 A. Like if somebody had a -- for example, a
3 clotting disorder. Let's say they had a
4 hypercoagulable situation where they had the
5 experience of blood clots, and they wanted to take
6 estrogen. This has been a time when we've denied
7 care.

8 Q. So how do you treat that person?

9 A. Well, usually what we would do is put them
10 maybe on an antiandrogen, something that would still,
11 for example, support their bone density but wouldn't
12 necessarily feminize their bodies.

13 There's been a -- there was a situation with
14 a patient that I had with androgen insensitivity
15 syndrome.

16 Well, would -- how are we going to
17 masculinize that person? We just can't, because they
18 have no androgen receptors. Testosterone is going to
19 be ineffective in their body. And so we would not
20 give them interventions.

21 Those are just a few examples.

22 For people with coagu- -- coagulation
23 issues, we work with the hematologist to figure out
24 if there are ways. Maybe that person goes on Heparin
25 or some kind of other blood thinner that minimizes

1 Somebody could, for example, have a
2 preexisting condition that might make the decision to
3 take hormones problematic.

4 I think that there are some times when
5 people cannot tolerate all the mechanisms of -- any
6 of the mechanisms of delivery, might be really
7 problematic.

8 I think sometimes people can't afford the
9 interventions if they're not covered by their
10 insurance.

11 There's probably others.

12 Q. In the context of somebody with a
13 preexisting condition that would have a negative
14 interaction with hormones --

15 A. Mm-hmm.

16 Q. -- for example, what if the patient said, I
17 completely understand all of this, but the distress
18 I'm experiencing from my gender incongruence is so
19 severe, that to me it is worth the risk, would you
20 still deny the intervention?

21 MR. SELDIN: Object to form.

22 THE WITNESS: I think it depends on what the
23 risk is.

24 BY MR. RAMER:

25 Q. What's an example of a risk where you would

1 their risk of blood clots.

2 But there are some situations where
3 medically you either have to sort things out first,
4 or you -- there's nothing you can do.

5 BY MR. RAMER:

6 Q. You can't provide them psychotherapy?

7 A. Well, you can, but almost everybody gets
8 psychotherapy anyway.

9 Q. And --

10 A. Does that resolve their gender dysphoria?
11 No.

12 Q. What happens to them if they cannot obtain
13 medical interventions but receive psychotherapy?

14 A. Well, it's only happened once in my clinic.

15 One time with somebody with androgen
16 sensitivity syndrome. And I never saw them after the
17 first visit, because medical interventions were off
18 the table for them. That person could go on to get
19 chest surgery, and that would probably significantly
20 help their gender dysphoria, at least to have a flat
21 chest.

22 Q. So what do you think Dr. Turban is talking
23 about when he says to Dr. Olson, "That's her model"?

24 A. I -- I have no idea what he's talking about.

25 Q. And are you familiar with the gender clinic

1 at Brown University?

2 A. Very minimally.

3 Q. Do you have an understanding of what their
4 clinical model is?

5 A. Well, Brown's clinic, my understanding is
6 it's a clinic for adults. And so there are several
7 clinics around the country for adult care that act on
8 an Informed Consent model.

9 Q. And so if Dr. Turban were saying that you
10 operate on an Informed Consent model, that would be
11 incorrect; is that right?

12 A. Yes.

13 MR. SELDIN: Object to form.

14 THE WITNESS: Oh, sorry.

15 Yes.

16 THE REPORTER: Exhibit 14.

17 (Deposition Exhibit 14 was marked for
18 identification by the court reporter.)

19 THE WITNESS: Thank you.

20 MR. RAMER: And, Counsel, I'll represent
21 that the top of your copy was cut off, but that the
22 witness -- the exhibit has the case number at the
23 top.

24 MR. SELDIN: Okay. Thank you.

25 ///

1 BY MR. RAMER:

2 Q. And, Dr. Olson-Kennedy, you've been handed
3 what's been marked as Olson-Kennedy Exhibit 14;
4 correct?

5 A. Yes.

6 Q. And this is an expert declaration that you
7 submitted in the case, Dekker v Marstiller; correct?

8 A. Yes.

9 Q. And I'd like to go to page 12 and the
10 carryover paragraph at the top, the first full
11 sentence. I'll read it first and ask if I read it
12 correctly.

13 It says:

14 "The WPATH SOC have been endorsed and cited
15 as authoritative by most major medical associations
16 in the United States, including the American Medical
17 Association, the American Psychiatric Association,
18 the American Psychological Association, the Endocrine
19 Society, the Pediatric Endocrine Society, the
20 American College of Physicians and the American
21 Academy of Family Physicians, among others."

22 Did I read that correctly?

23 A. Yes.

24 Q. And going back to your declaration in this
25 case, Exhibit 1, on page 9, paragraph 32, I'll read

1 that and ask if I read it correctly.

2 It says:

3 "The WPATH SOC have been cited as
4 authoritative by the major medical associations in
5 the United States, including the American Academy of
6 Pediatrics, the American Medical Association, the
7 American Psychiatric Association, the American
8 Psychological Association, The Endocrine Society, the
9 Pediatric Endocrine Society, the American College of
10 Physicians, and the American Academy of Family
11 Physicians."

12 Did I read that correctly?

13 A. Yes.

14 Q. And so in Dekker, you said that all of these
15 organizations had endorsed the WPATH SOC, but you do
16 not say that in your declaration in this case;
17 correct?

18 A. Correct.

19 Q. And why did you remove the assertion that
20 the WPATH SOC were endorsed by these major medical
21 associations?

22 MR. SELDIN: Object to form.

23 THE WITNESS: Well, what happened was that I
24 think that in the process of one of these depositions
25 or something, it was brought to my attention that

1 endorsement is a technical -- actually has rather
2 than, like, oh, yeah, I endorse that, meaning I agree
3 with it. Because it is a technical word, I wasn't
4 sure if they had, this is our endorsement of these
5 guidelines.

6 And so I took it out.

7 BY MR. RAMER:

8 Q. And so do you agree that it was wrong in
9 Dekker to say that those organizations endorsed the
10 WPATH SOC?

11 MR. SELDIN: Object to form.

12 THE WITNESS: Just depends on how you're
13 using the word.

14 BY MR. RAMER:

15 Q. If you think it could be used correctly, why
16 did you take it out of your declaration in this case?

17 MR. SELDIN: Object to form.

18 THE WITNESS: I just didn't want to confuse
19 anyone. There's not -- like I said, there's not like
20 the stamp of endorsement on the -- the WPATH
21 guidelines.

22 I use the word "endorse" as a just
23 colloquialism for we agree with these, we think these
24 are a good idea. That's why.

25 ///

1 BY MR. RAMER:

2 Q. And so it's your opinion that these medical
3 organizations have endorsed the WPATH SOC; is that
4 right?

5 A. With the colloquial meaning of "endorse,"
6 yes.

7 Q. And you're a member of the American Academy
8 of Pediatrics; correct?

9 A. I am.

10 Q. Were you involved with AAP's review of the
11 WPATH Standards of Care 8?

12 A. No.

13 Q. Do you know who was?

14 A. No.

15 Q. You don't know whether Jason Rafferty was
16 involved?

17 A. Yes. I -- that -- I didn't know that that
18 was the specific thing that he did.

19 Q. Are there any other names that were involved
20 that you know of?

21 A. I didn't actually even know that happened.

22 What I know is that Jason wrote something
23 about it. But I don't -- I didn't know that there
24 was a formal process where the AA- -- that's what I
25 mean by "endorsement."

1 I didn't know if there was a formal process
2 where the AAP said, let's look through the SOC 8 and
3 do whatever the word was that you described it.

4 MR. SELDIN: And, Mr. Ramer, I'm sorry to
5 interrupt.

6 I'll just note for the record that these two
7 lists are slightly different in terms of what's
8 included and what's not.

9 I know you read them out, but just --

10 (Reporter clarification.)

11 MR. SELDIN: I apologize.

12 I'm just noting for the record that
13 Mr. Ramer read out the different lists of medical
14 organizations across the declarations. I don't
15 believe they're exactly identical.

16 THE WITNESS: I think it might just be in
17 just a different order.

18 MR. SELDIN: American Academy of Pediatrics.

19 MR. RAMER: Got it. Thank you.

20 MR. SELDIN: Not to be that guy, but...

21 MR. RAMER: We're lawyers, we all have to
22 be.

23 Q. And do you know Jason Rafferty?

24 A. I do.

25 Q. Have you worked with him?

1 A. I have not.

2 Q. Have you ever discussed the use of puberty
3 blockers as a treatment for gender dysphoria with a
4 representative from a pharmaceutical company?

5 A. Yes.

6 MR. SELDIN: Object to --

7 THE WITNESS: Oh.

8 MR. SELDIN: Object to form.

9 You can answer.

10 THE WITNESS: Yes, I have.

11 BY MR. RAMER:

12 Q. Which company?

13 A. Endo Pharmaceuticals.

14 Q. And what was the context of that discussion?

15 A. Endo Pharmaceuticals asked me to come and
16 give a presentation to their reps. I actually don't
17 remember who the audience was, but it was
18 educational.

19 Q. Did you get paid for that?

20 A. I did.

21 Q. Do you recall how much?

22 A. No. It's a really long time ago.

23 Q. And do you know Dr. Kara Connelly?

24 A. I do.

25 Q. Was she at that event?

1 A. I have no memory of that.

2 Q. And what was the substance of your
3 presentation?

4 A. Transgender Care 101.

5 Q. And Endo Pharmaceuticals develops drugs that
6 are used as puberty blockers; correct?

7 A. Yes.

8 Q. And apart from the presentation that you
9 gave, you have never spoken about the use of puberty
10 blockers as a treatment for gender dysphoria with any
11 other representative of the pharmaceutical company;
12 is that correct?

13 MR. SELDIN: Object to form.

14 THE WITNESS: Many years ago, I discussed
15 the possibility of Endo Pharmaceuticals sponsoring a
16 study so that we could get FDA approval specifically
17 for gender dysphoria.

18 That's the only contact I've had with them.

19 BY MR. RAMER:

20 Q. What about any other pharmaceutical
21 companies?

22 A. I don't think so. Not that I can remember
23 offhand.

24 Q. And what was the result of the attempt to
25 get Endo to sponsor the study for FDA approval?

1 A. They did not want to sponsor a study for the
2 FDA approval.

3 Q. Do you recall why?

4 A. They said that they did not want to tolerate
5 the bad press.

6 Q. Do you think that is a good reason for not
7 sponsoring a study?

8 MR. SELDIN: Object to form.

9 THE WITNESS: A hundred percent no.

10 BY MR. RAMER:

11 Q. And have you tried to persuade Endo
12 Pharmaceuticals since then, or any other
13 pharmaceutical company, to sponsor a study to get
14 FDA approval for puberty blockers?

15 A. No, not that I recall.

16 Q. Going from puberty blockers to cross-sex
17 hormones, have you ever discussed the use of
18 cross-sex hormones as a treatment for gender
19 dysphoria in minors with a representative from a
20 pharmaceutical company?

21 A. The same thing that I just talked about,
22 Endo Pharmaceuticals.

23 Q. The presentation and then the attempt to get
24 the study; is that right?

25 A. Mm-hmm. But the attempt to get the study

1 was not about gender-forming hormones. It was just
2 about blockers.

3 Q. And, Dr. Olson-Kennedy, I think that's all
4 the questions that I have for now.

5 And so I'll turn it over to pass the
6 witness.

7 MR. SELDIN: Thank you.

8 I suspect that I have nothing, but if you'll
9 give me five minutes.

10 MR. RAMER: Absolutely.

11 THE VIDEOGRAPHER: Off the record then?

12 MR. RAMER: Yes.

13 THE VIDEOGRAPHER: The time is 1:30 p.m.

14 We are now off the record.

15 (Off record.)

16 THE VIDEOGRAPHER: One moment, please.

17 The time is 1:32 [sic] p.m.

18 We are back on the record.

19 MR. SELDIN: Counsel for plaintiffs does not
20 have any questions for Dr. Olson-Kennedy, but we will
21 read and sign.

22 MR. RAMER: And thank you very much for your
23 time today, Dr. Olson-Kennedy.

24 THE WITNESS: You're welcome.

25 THE VIDEOGRAPHER: One moment, please, and

1 I'll take us off the record.

2 This concludes today's videotaped deposition
3 of Johanna Olson-Kennedy.

4 The time is 1:31 p.m.

5 We are now off the record.

6 THE REPORTER: Mr. Seldin, are you ordering
7 a copy of the transcript?

8 MR. SELDIN: Yes. Thank you.

9 THE VIDEOGRAPHER: And will you need video?

10 MR. SELDIN: Yes, please. I'll have what
11 he's having.

12 THE REPORTER: Just to be clear, you want it
13 expedited also?

14 MR. SELDIN: Yes. Whenever they're getting
15 theirs, I would like it as well.

16 Thank you.

1
2 DECLARATION UNDER PENALTY OF PERJURY

3
4 I, JOHANNA OLSON-KENNEDY, M.D., do hereby
5 certify under penalty of perjury that I have read the
6 foregoing transcript of my deposition taken on
7 October 7, 2024; that I have made such corrections as
8 appear noted herein in ink, initialed by me; that my
9 testimony as contained herein, as corrected, is true
10 and correct.

11
12 DATED this ____ day of _____, 20____,
13 at _____, California.

14
15
16
17 _____
18 JOHANNA OLSON-KENNEDY, M.D.
19
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21
22
23
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25

REPORTER'S CERTIFICATION

I, Marceline F. Noble, a Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing witness was by me duly sworn; that the deposition was then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed into typewriting under my direction; that the foregoing is a true record of the testimony and proceedings taken at that time.

IN WITNESS WHEREOF, I have subscribed my name this 13th day of October, 2024.

Marceline F. Noble, CSR No. 3024

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JOHANNA OLSON-KENNEDY, M.D.

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